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SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

ROBIN CARNAHAN

SECRETARY OF STATE

MISSOURI REGISTER

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Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at http://www.sos.mo.gov/adrules/pubsched.asp

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The rules are codified in the *Code of State Regulations* in this system—

Title	***Code of State Regulations***	**Division**	**Chapter**	**Rule**
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—The most recent version of the statute containing the section number and the date.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons and findings which support its conclusion that there is an immediate danger to the public health, safety or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 35—Children's Division
Chapter 30—Voluntary Placement Agreement

EMERGENCY RULE

13 CSR 35-30.010 Voluntary Placement Agreement Solely for the Purpose of Accessing Mental Health Services and Treatment for Children Under Age Eighteen (18)

PURPOSE: This rule sets forth procedures to be followed to divert children from Children's Division (CD) legal custody when a parent is unable to access or afford clinically indicated mental health services for their child and the child otherwise is not the subject of parental abuse, neglect or abandonment.

*EMERGENCY STATEMENT: The division has determined that an emergency rule is necessary to comply with section 210.108, RSMo as enacted by the 92nd General Assembly in HB 1453. The division finds that an immediate danger to the health, safety and welfare to the citizens of Missouri exists inasmuch as this action is necessary in order to ensure that children with mental health needs are able to access the services that are needed. The division finds that this emergency rule is necessary to preserve a compelling governmental interest in providing access to children who have mental health needs and otherwise cannot access the services. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency rule is limited to circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. The division believes the emergency rule is fair to all interested persons and parties under the circumstances. This emergency rule was filed December 23, 2004, effective January 2, 2005, expires June 30, 2005.*

(1) Parents or legal guardians (parents) who are considering relinquishing custody solely for the purpose of accessing clinically indicated mental health services for their child or who otherwise cannot afford such services shall be referred by the Children's Division (CD) or Juvenile Court to the Department of Mental Health (DMH) or their designee for an assessment of eligibility to enter into a Voluntary Placement Agreement (VPA).

(2) The Department of Social Services-Children's Division (DSS-CD) and the DMH shall develop protocol, policy and procedure to assess the level and extent of services needed for such children and to develop criteria for determining whether a child may be appropriate for a VPA in accordance with Chapter 536, RSMo.

(3) If DMH determines pursuant to the procedures, policies, and protocols as indicated in section (2), above, that the child requires services that cannot be provided in the home and the parent is currently unable to access or financially afford the clinically indicated care the child requires, the parent may enter into a VPA with the DSS-CD.

(A) A VPA means a written agreement between the DSS-CD and a parent, legal guardian, or custodian of a child under age eighteen (18) in need of out-of-home placement, solely because he/she is in need of mental health treatment and services.

(B) A VPA developed following a DMH assessment and certification of appropriateness authorizes the DSS-CD to administer the placement and care of a child while the parent, legal guardian, or custodian of the child retains legal custody.

(4) The DSS-CD will authorize the DMH to place the child, administer the placement, and provide care and treatment for the child while he/she is under the Voluntary Placement Agreement.

(5) The DMH shall ensure that a child's placement, under the VPA, shall be in the most appropriate and least restrictive environment available for the shortest period of time as clinically indicated.

(6) The VPA shall be effective the date the child is placed. Voluntary Placement Agreements may be for as short a period as the parties may agree in the best interests of the child but under no circumstances shall the total period of time that a child shall remain in care under a VPA exceed one hundred eighty (180) days. Subsequent agreements may be entered into, but the total period of placement of the child under a single VPA or a series of VPAs shall not exceed one hundred eighty (180) days without the express authorization of the director of the Children's Division or his/her designee.

(7) The parents, DMH and DSS-CD shall hold a family support team meeting to develop a permanency/treatment plan for the child either prior to or within seventy-two (72) hours of the date of placement of the child pursuant to a VPA. The permanency/treatment plan shall be completed and in place no later than sixty (60) days from the date that the child is placed according to the agreement.

(8) The parents, the DSS-CD and DMH shall hold a family support team meeting no later than one hundred (100) days from the date that the child is placed pursuant to a VPA to determine whether:

(A) The parties have exercised reasonable efforts to finalize the permanency plan; and

(B) Whether it is in the best interests of the child to either terminate the VPA and reunite the child with the child's parents or whether it is in the best interests of the child to continue the child in care beyond the expiration date of the VPA.

(9) The DSS-CD shall maintain responsibility for compliance with all Federal Title IV-E requirements. All Voluntary Placement Agreements shall be consistent with the requirements of sections 210.108 and 210.710, RSMo and Title IV-E of the Social Security Act and its implementing regulations, including, but not limited to 42 U.S.C. Section 672.

(10) DMH shall develop and submit to DSS-CD at prescribed intervals a report of services provided to any child served under a VPA. Such report shall include any information identified by DSS-CD as required for federal reporting purposes.

(11) The VPA may be terminated by the DSS-CD upon ten (10) days written notice to the parties.

(12) The parent(s) may terminate the VPA for any reason at any time by providing either oral or written notification to DSS-CD. Upon receipt of such notice the VPA shall immediately terminate and the child shall be returned to the legal and physical custody of the parents.

(13) All VPAs shall be in writing and shall be on a form approved by the DSS-CD in consultation with the DMH.

AUTHORITY: section 210.108, RSMo Supp. 2004. Emergency rule filed Dec. 23, 2004, effective Jan. 2, 2005, expires June 30, 2005. A proposed rule covering the same material is published in this issue of the ***Missouri Register****.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 35—Children's Division
Chapter 50—Licensing

EMERGENCY RULE

13 CSR 35-50.010 Accreditation as Evidence for Meeting Licensing Requirements

PURPOSE: This rule establishes the procedures to be followed in order for an organization to qualify for a license under sections 210.481 through 210.511, RSMo by the agency being accredited by Council on Accreditation of Services for Children and Families, Inc., the Joint Commission on Accreditation of Healthcare Organizations, or the Commission on Accreditation of Rehabilitation Facilities (accreditation bodies).

EMERGENCY STATEMENT: The division has determined that an emergency rule is necessary to comply with section 210.112, RSMo as enacted by the 92nd General Assembly in HB 1453. The division finds that an immediate danger to the health, safety and welfare to the citizens of Missouri exists inasmuch as this action is necessary in order to ensure the safety of children which are receiving services from the providers who are accredited and therefore can obtain a license from the division. The division finds that this emergency rule is necessary to preserve a compelling governmental interest in maintaining the safety of children in Missouri. A proposed rule, which covers the same material, is published in this issue of the ***Missouri Register****. The scope of this emergency rule is limited to circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The division believes the emergency rule is fair to all interested persons and parties under the circumstances. This emergency rule was filed December 23, 2004, effective January 2, 2005, expires June 30, 2005.*

(1) The Children's Division shall accept accreditation by Council on Accreditation of Services for Children and Families, Inc., the Joint Commission on Accreditation of Healthcare Organizations, or the Commission on Accreditation of Rehabilitation Facilities, as specified in section (2) of this rule, as *prima facie* evidence that the organization meets licensing requirements under sections 210.481 through 210.511, RSMo.

(2) Type of License.

(A) The organization shall provide to the Children's Division, sufficient evidence that they are accredited in the service or program for which they are requesting a license.

(B) If a service or program, including but not limited to child placing, maternity, infant/toddler, residential treatment, and intensive residential treatment in residential child care, is not accredited by the accrediting body, than the organization must apply for and meet all other licensing requirements as put forth by the division.

(3) Application/Reapplication for license for accredited organizations:

(A) The organization shall present to the division—

1. A copy of the organization's official final accreditation report and accreditation certificate; and

2. A list of operating sites which includes the capacity served, the gender served, and the ages served by that organization. This list must be updated if there is a change in operating sites by the organization;

(B) If the organization has not been previously licensed by the state of Missouri, an onsite visit may be required by the division before a license is issued;

(C) The division shall examine the areas that the organization is applying for a license. The division then shall issue a corresponding license for those areas in which the organization is accredited. The license shall be valid for the period of time up to two (2) years, or when the organization's accreditation expires, whichever is shorter;

(D) Nothing in this section will result in the loss of license if the accreditation certificate has expired, but the organization is still in good standing and the re-accreditation process is being pursued. The division may, at its discretion, request a letter of good standing from the accrediting body; and

(E) Any denial or revocation of license based upon an organization's accreditation standing is entitled to a hearing as specified under the licensing rules or they may undergo the licensing process and meet all licensing rules in order to obtain a license.

(4) Information Sharing.

(A) The organization shall notify the division immediately of any sentinel event and of any revocation of accreditation.

(B) Sentinel events are as defined by the accrediting body, but shall at a minimum include the following:

1. A death of a child in one of the organization's facilities; or

2. A serious injury of a child in one of the organization's facilities; or

3. A fire in a location routinely occupied by children, which requires the fire department to be called; or

4. An allegation of child abuse, physical or sexual, or neglect which is substantiated by the division or through an internal investigation by the organization which occurs within a facility; or

5. An employee is terminated from employment in relation to the safety and care of children; or

6. There is any change in the chief executive officer; or

7. There is a lawsuit filed against the organization by or on behalf of a person who is or was in the organization's care; or

8. Any known criminal charges are filed against the facility, organization, any resident of the facility, or any employee or volunteer who has contact with children.

(C) The organization shall notify the division of the entrance, exit and any performance review meetings of the accrediting body which are held in conjunction with the accreditation of the organization. The division has a right to attend any or all of these meetings between the organization and the accrediting body.

(5) The division may make such inspections and investigations as it deems necessary to conduct an initial visit to a facility not previously licensed, for investigative purposes involving complaints of alleged child abuse or neglect, at reasonable hours to address a complaint concerning the health and safety of children which the organization serves, or any other mutually agreed upon time.

AUTHORITY: section 210.112, RSMo Supp. 2004. Emergency rule filed Dec. 23, 2004, effective Jan. 2, 2005, expires June 30, 2005. A proposed rule covering the same material is published in this issue of the ***Missouri Register****.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 10—Nursing Home Program

EMERGENCY AMENDMENT

13 CSR 70-10.110 Nursing Facility Reimbursement Allowance. The division is amending sections (1) and (2) and adding section (3).

PURPOSE: This amendment clarifies the NFRA regulation, updates the applicable quarterly survey to be used in determining the NFRA assessment and provides for an adjustment to the NFRA for qualifying facilities.

EMERGENCY STATEMENT: This emergency amendment is necessary to clarify the NFRA regulation, update the applicable quarterly survey to be used in determining the NFRA assessment and provide for an adjustment to the NFRA for qualifying facilities. It must be implemented on a timely basis to ensure that quality nursing facility services continue to be provided to Medicaid patients in nursing facilities. As a result, the Division of Medical Services finds an immediate danger to public health, safety and/or welfare and a compelling governmental interest, which requires emergency action. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The Division of Medical Services believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed December 17, 2004, effective January 1, 2005, expires June 29, 2005.*

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Nursing Facility Reimbursement Allowance (NFRA). NFRA shall be assessed as described in this section.

(A) Definitions.

1. Nursing facility. An institution or a distinct part of an institution which—

A. Is primarily engaged in providing to residents—

(I) Skilled nursing care and related services for residents who require medical or nursing care; or

(II) Rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

(III) On a regular basis, health-care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases; and

B. Has in effect a transfer agreement with one (1) or more hospitals as required by federal law; and

C. Meets the requirements for a nursing facility described in section 1919(b)–(d) of the Social Security Act; or

D. Is licensed in accordance with Chapter 198, RSMo as a skilled nursing facility.

2. Fiscal period. A facility's twelve (12)-month fiscal reporting period covering the same twelve (12)-month period as its federal tax year.

3. Department. Department of Social Services.

4. Director. Director of the Department of Social Services.

5. Division. Division of Medical Services, Department of Social Services.

6. *[Division of Aging]* **Department of Health and Senior Services (DHSS)**. The *[division of the Department of Social Services]* **Missouri state agency** responsible for *[surveys, certification and licensure of nursing facilities]* **licensing and inspecting all long-term care facilities operating in Missouri and certifying annually those facilities participating in the Medicare or Medicaid program**.

7. Engaging in the business of providing nursing facility services. Accepting payment for nursing facility services rendered.

8. Quarterly survey. The survey filled out each quarter by a nursing facility providing data on its licensed and certified beds and the related resident occupancy days (ROD) that is submitted to the DHSS. The survey form, "Missouri Department of Health and Senior Services, Division of Senior Services and Regulation, ICF/SNF Certificate of Need Quarterly Survey" (form MO 886-9001 (6-95)), incorporated by reference in this rule, is published by the Department of Health and Senior Services, Division of Senior Services and Regulation, PO Box 570, Jefferson City, MO 65102. This rule does not incorporate any subsequent amendments or additions.

9. Applicable quarterly survey. The quarterly survey used by the division from which the patient occupancy days are taken to determine the NFRA assessment for a given period as set forth in section (2).

*[8.]***10.** Patient occupancy days. The number of days **that residents occupied the licensed beds in a nursing facility** as shown on the *[Division of Aging's]* quarter**ly** survey**, line D**. **"Number of occupied RODs (days patients in beds or beds held)."**

*[9.]***11.** *[Total]* **Annualized level of** patient occupancy days. **The annual level of patient occupancy days used to determine the annual NFRA assessment.**

A. For existing nursing facilities whose NFRA assessment is set in accordance with (1)(B)1. of this regulation, the annualized level of patient occupancy days is calculated by taking *[T]***t**he number of patient occupancy days shown on **line D. of** the *[Division of Aging's]* quarter**ly** survey multiplied by four (4).

B. For nursing facilities whose NFRA assessment is not set by the general rule set forth in (1)(B)1. (i.e., it is an exception set under (1)(B)1.A., is a new facility set under (1)(B)2., qualifies for a NFRA adjustment in accordance with section (3), etc.), the annualized level of patient occupancy days may be calculated differently and is set forth in those sections.

*[10.]***12.** Licensed beds. Any skilled nursing facility or intermediate care facility bed meeting the licensing requirement of the *[Division of Aging or the]* Missouri Department of Health **and Senior Services**.

13. Licensed bed days. The total number of patient days available for use during a given period for all licensed beds. For purposes of this regulation, licensed bed days are calculated for an annual period and is the number of licensed beds times three hundred sixty-five (365) days.

14. Change of ownership. A change in the ownership, control, operator or leasehold interest.

(B) Each nursing facility, except any nursing facility operated by the Department of Mental Health, engaging in the business of providing nursing facility services in Missouri shall pay a Nursing Facility Reimbursement Allowance (NFRA).

1. The NFRA owed for existing nursing facilities shall be calculated by multiplying the NFRA rate by the annualized level of patient occupancy days from the applicable *[Division of Aging ICF/SNF Certificate of Need]* Quarterly Survey. The NFRA shall be divided by and collected over the number of months for which each NFRA rate is effective. The NFRA rates, effective dates and applicable quarterly surveys are set forth in section (2).

A. Exceptions.

(I) If an existing nursing facility's applicable quarterly survey, as set forth in section (2), does not represent a full quarter's worth of days due to a termination, temporary closure, change of ownership, etc., the **annualized level of** patient occupancy days used to determine the NFRA shall be the greater of:

(a) The **annualized level of patient occupancy days from the** quarterly survey immediately prior to the applicable quarterly survey, if it represents a full quarter's worth of days; or

(b) Fifty percent (50%) of licensed bed*/s/* **days (i.e., number of licensed beds times three hundred sixty-five (365) days times fifty percent (50%))**.

(II) If an existing nursing facility did not have patient occupancy information included on the applicable quarterly survey due to a termination, temporary closure, change of ownership, etc., the **annualized level of** patient occupancy days used to determine the NFRA shall be the greater of:

(a) The **annualized level of patient occupancy days from the** quarterly survey immediately prior to the applicable quarterly survey, if it represents a full quarter's worth of days; or

(b) Fifty percent (50%) of licensed bed*/s/* **days**.

(III) If a nursing facility has ICF licensed beds and SNF licensed beds and none of the beds are Medicaid certified, only the SNF beds are subject to NFRA. The **annualized level of** patient occupancy days used to determine the NFRA shall be determined by multiplying the occupancy percentage from the applicable quarterly survey by the *[annualized level of patient occupancy]* **licensed bed** days *[based on]* **for** the SNF licensed beds **(i.e., number of SNF licensed beds times three hundred sixty-five (365) days)**.

(IV) If two (2) existing nursing facilities merge, with one (1) nursing facility terminating and transferring its beds to the remaining facility, the NFRA for the two (2) previously independent nursing facilities shall be added together and assessed to the remaining facility.

2. The initial NFRA owed by a newly licensed nursing facility that just opened as a result of receiving a Certificate of Need (CON) for a new nursing facility shall be calculated by multiplying the NFRA rate by the annualized level of patient occupancy days based on fifty percent (50%) of licensed bed*/s/* **days**. The NFRA shall be prorated for the number of months remaining in the NFRA period. If a nursing facility's licensure date is after the first day of a month, the NFRA will be collected beginning with the first day of the month following the actual licensure date.

3. If a nursing facility ceases to provide nursing facility services, the nursing facility is not required to pay the NFRA during the months in which it does not have residents, even though it may retain a license due to temporary closure for renovations, replacement, etc. **If a nursing facility provided nursing facility services for any portion of a month, it shall pay the NFRA for the entire month (i.e., the NFRA shall not be prorated for the month in which it ceases to provide nursing facility services).** If the facility reopens, it shall resume paying the NFRA. It shall owe the same NFRA as it did prior to closing, if the NFRA has not changed per section (2) below. If the NFRA has changed, the facility shall be assessed in accordance with paragraph (1)(B)1. above.

(F) Each nursing facility, upon receiving written notice of the final determination of its Nursing Facility Reimbursement Allowance may file a protest with the director of the department setting forth the grounds on which the protest is based, within thirty (30) days from the date of receipt of written notice from the department. The director of the department shall reconsider the determination and, if the nursing facility so requested, the director or the director's designee shall grant the nursing facility a hearing to be held within forty-five (45) days after the protest is filed, unless extended by agreement between the nursing facility and the director. The director shall issue a final decision within forty-five (45) days of the completion of the hearing. After a final decision by the director, a nursing facility's appeal of the director's final decision shall be to the Administrative Hearing Commission in accordance with sections 208.156, RSMo and 62**1**.055, RSMo.

(2) NFRA Rates. The NFRA rates determined by the division, as set forth in (1)(B) above, are as follows:

(H) The NFRA will be seven dollars and thirty cents ($7.30) per patient occupancy day, effective July 1, 2001. The applicable quarterly survey for this period shall be the Division of Aging's December 2000 quarterly survey**;** *[and]*

(I) The NFRA will be eight dollars and forty-two cents ($8.42) per patient occupancy day, effective July 1, 2003. The applicable quarterly survey for this period shall be the Department of Health and Senior Services' December 2002 quarterly survey*[.]***;**

(J) Effective January 1, 2005, the applicable quarterly survey shall be the June 2004 quarterly survey. The NFRA will continue to be eight dollars and forty-two cents ($8.42) per patient occupancy day; and

(K) Effective July 1, 2005, the applicable quarterly survey shall be updated at the beginning of each state fiscal year using the previous December's quarterly survey.

(3) NFRA Adjustment Request. A facility being assessed the NFRA may request that its current NFRA assessment be adjusted, as set forth below.

(A) Qualifying Criteria. In order for a facility to receive an adjustment to its current NFRA assessment, it must meet all of the following criteria:

1. The facility must decrease its licensed bed capacity by at least fifteen percent (15%).

2. The facility must draft a written statement documenting that the decrease in licensed bed capacity is intended to be permanent.

A. If the facility increases its licensed capacity back to the original capacity within one (1) year of the decrease, the NFRA Adjustment shall be voided and the facility shall resume paying the original NFRA beginning with the first of the month in which the facility made the request to DHSS to increase licensed capacity.

3. The annualized level of patient occupancy days currently being assessed is not possible to attain because it is greater than one hundred percent (100%) of its new licensed capacity. For example, assume a facility had one hundred thirty (130) licensed beds and was being assessed on an average of one hundred (100) beds:

A. If a facility decreased its license by twenty (20) beds, being left with a total of one hundred ten (110) licensed beds, the facility could still obtain the occupancy at which it was assessed (i.e., one hundred (100) beds being assessed is less than the one hundred ten (110) licensed bed capacity). Therefore, it would not meet the criteria for a NFRA Adjustment.

B. If a facility decreased its license by forty (40) beds, being left with a total of ninety (90) licensed beds, the facility could not obtain the occupancy at which it was assessed (i.e., one hundred (100) beds being assessed is greater than the ninety (90) licensed bed capacity). Therefore, it would meet the criteria for a NFRA Adjustment.

4. The facility must submit a written request to the division that includes an explanation as to why it believes it qualifies for an adjustment to its NFRA and documentation supporting its request. The following documentation is required:

A. A copy of the facility's request submitted to the DHSS and/or the CON program that its licensed bed capacity be decreased.

B. A copy of the license issued as a result of the request for the decrease and all licenses issued from that point forward to the current license.

C. If the facility's request submitted to the DHSS and/or the CON program to decrease its licensed bed capacity did not include a statement that the facility intended for the decrease to be permanent, such a statement must be submitted with the NFRA Adjustment Request.

D. The division may obtain this documentation and any other documentation it deems relevant to satisfy itself that the facility's licensed bed capacity has been decreased and the facility intends for the decrease to be permanent from the facility, the DHSS, the CON program, or any other source it deems appropriate.

E. If the division makes a written request for additional information and the facility does not comply within ninety (90) days of the request, the division shall consider the NFRA Adjustment Request withdrawn.

(B) Calculation of Adjustment. A nursing facility meeting the criteria for a NFRA Adjustment shall have its NFRA recalculated and it shall replace the current NFRA. The revised, adjusted NFRA shall be calculated as follows:

1. The facility's new, decreased licensed bed capacity shall be multiplied by three hundred sixty-five (365) days to determine the annualized level of patient occupancy days.

2. The new annualized level of patient occupancy days shall be multiplied by the current NFRA rate set forth in section (2) to determine the revised annual assessment.

3. The revised annual assessment shall be divided by twelve (12) months to determine the revised monthly assessment that the facility will owe beginning with the effective date of the adjustment.

(C) Effective Date of NFRA Adjustment. The effective date of the NFRA Adjustment shall be the first day of the month following the date the request is received; it will not be retroactive back to the effective date of the original NFRA.

*AUTHORITY: sections 198.401, 198.403, 198.406, 198.409, 198.412, 198.416, 198.418, 198.421, 198.424, 198.427, 198.431, 198.433, 198.436 and 208.201, RSMo 2000 and 198.439, RSMo Supp. 2003. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 21, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 15, 1994, effective July 30, 1995. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed Dec. 17, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RESCISSION

22 CSR 10-2.010 Definitions. This rule established the policy of the board of trustees regarding the key terms within the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded due to the filing of a new emergency and proposed rule.

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rescission is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be registered immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 20, 2004, effective January 1, 2005, expires June 29, 2005.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.010 Definitions

PURPOSE: This rule establishes the policy of the board of trustees regarding the key terms within the Missouri Consolidated Health Care Plan relative to state members.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made

against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 20, 2004, effective January 1, 2005, expires June 29, 2005.*

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) When used in this chapter's rules or the state plan document, these words and phrases have the meaning—

(A) Accident—An unexpected happening resulting in an injury which is not due to any fault or misconduct on the part of the person injured;

(B) Actively at work—You are considered actively at work when performing in the customary manner all of the regular duties of your occupation with the employer either at one (1) of the employer's regular places of business or at some location which the employer's business requires you to travel to perform your regular duties or other duties assigned by your employer. You are also considered to be actively at work on each day of a regular paid vacation or nonworking day on which you are not totally disabled, but only if you are performing in the customary manner all of the regular duties of your occupation with the employer on the immediately preceding regularly scheduled workday;

(C) Administrative guidelines—The interpretation of the plan document as approved by the plan administrator, developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered;

(D) Automatic reinstatement maximum—The maximum annual amount that can be reinstated to an individual's lifetime benefit;

(E) Benefit year—The twelve (12)-month period beginning January 1 and ending December 31;

(F) Benefits—Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator;

(G) Care Support Program—A voluntary program that helps manage a chronic condition with outpatient treatment;

(H) Claims administrator—An organization or group responsible for the processing of claims and associated services for the plan's self-insured benefit programs and preferred provider organization (PPO);

(I) Co-pay plan—A set of benefits similar to a health maintenance organization option;

(J) Cosmetic surgery—A procedure performed primarily to preserve or improve appearance rather than restore the anatomy and/or function of the body which are lost or impaired due to illness or injury;

(K) Covered benefits—A schedule of covered services and charges, including chiropractic services, which are payable under the plan;

(L) Custodial care—Care designed essentially to assist an individual to meet the activities of daily living; for example, assistance in bathing, supervision of medication which can usually be self-administered and which does not entail or require the continuing attention of trained medical or paramedical personnel;

(M) Dependent-only participation—Participation of certain survivors of employees. Dependent participation may be further defined to include the deceased employee's: 1) spouse only; 2) child(ren) only; or 3) spouse and child(ren);

(N) Dependents—The lawful spouse of the employee, the employee's unemancipated child(ren) and certain survivors of employees, as provided in the plan document and these rules, for whom application has been made and has been accepted for participation in the plan;

(O) Eligibility date—Refer to 22 CSR 10-2.020 for effective date provisions.

1. Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of employment or reemployment.

2. Employees transferred from a state department with coverage under another medical care plan into a state department covered by this plan and their eligible dependents who were covered by the other medical care plan will be eligible for participation subject to any applicable pre-existing conditions as outlined in the plan document.

3. Employees who terminate all employment with the state (not simply move from one agency to another) and are rehired as a new state employee before termination of participation, and their eligible dependents who were covered by the plan, will be eligible for participation immediately.

4. Employees who terminate all employment with the state (not simply move from one agency to another) and are rehired as a new state employee in the subsequent month, and their eligible dependents who were covered by the plan, will be eligible for participation retroactive to the date following termination of participation;

(P) Emancipated child(ren)—A child(ren) who is—

1. Employed on a full-time basis;

2. Eligible for group health benefits in his/her own behalf;

3. Maintaining a residence separate from his/her parents or guardian—except for full-time students in an accredited school or institution of higher learning; or

4. Married;

(Q) Employee and dependent participation—Participation of an employee and the employee's eligible dependents. Dependent participation may be further defined to include the participating employee's: 1) spouse only; 2) child(ren) only; or 3) spouse and child(ren). Any individual eligible for participation as an employee is not eligible as a dependent, except as noted in 22 CSR 10-2.020(1)(A)3.;

(R) Employee only participation—Participation of an employee without participation of the employee's dependents, whether or not the employee has dependents;

(S) Employees—Employees of the state and present and future retirees from state employment who meet the eligibility requirements as prescribed by state law;

(T) Employer—The state department that employs the eligible employee as defined above;

(U) Executive director—The administrator of the Missouri Consolidated Health Care Plan (MCHCP) who reports directly to the plan administrator;

(V) Health maintenance organization (HMO)—A plan that provides for a wide range of comprehensive health care services for a specified group at a fixed periodic prepayment;

(W) Home health agency—An agency certified by the Missouri Department of Health and Senior Services, or any other state's licensing or certifying body, to provide health care services to persons in their homes;

(X) Hospice—A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill;

(Y) Hospital.

1. An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24) hour-a-day nursing service by a registered nurse (RN) on duty or call.

2. An institution not meeting all the requirements of (1)(Y)1. of this rule, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

3. An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).

4. A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

5. A residential alcoholism, chemical dependency or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction. In no event shall the term hospital include a skilled nursing facility or any institution or part thereof which is used primarily as a skilled nursing facility, nursing home, rest home or facility for the aged;

(Z) Lifetime—The period of time you or your eligible dependents participate in the plan;

(AA) Medical benefits coverage—Services that are received from providers recognized by the plan and are covered benefits under the plan;

(BB) Medically necessary—Services and/or supplies usually rendered or prescribed for the specific illness or injury;

(CC) Nurse—A registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule;

(DD) Open enrollment period—A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year;

(EE) Out-of-area—Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria;

(FF) Out-of-network—Providers that do not participate in the member's health plan;

(GG) Participant—Any employee or dependent accepted for membership in the plan;

(HH) Physically or mentally disabled—The inability of a person to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition;

(II) Physician/Doctor—A licensed practitioner of the healing arts, acting within the scope of his/her practice as licensed under section 334.021, RSMo;

(JJ) Plan—The program of health care benefits established by the trustees of the Missouri Consolidated Health Care Plan as authorized by state law;

(KK) Plan administrator—The trustees of the Missouri Consolidated Health Care Plan;

(LL) Plan document—The statement of the terms and conditions of the plan as adopted by the plan administrator in the "2005 Missouri Consolidated Health Care Plan State Employee Member Handbook" and incorporated by reference in this rule, as published in August, 2004 by the Missouri Consolidated Health Care Plan, PO Box 104355, Jefferson City, MO 65110. This rule does not incorporate any subsequent amendments or additions;

(MM) Plan year—Same as benefit year;

(NN) Point-of-service (POS)—A plan which provides a wide range of comprehensive health care services, like an HMO, if in-network providers are utilized, and like a PPO plan, if non-network providers are utilized;

(OO) Pre-admission testing—X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission;

(PP) Preferred provider organization (PPO)—An arrangement with providers where discounted rates are given to members of the plan who, in turn, are offered a financial incentive to use these providers;

(QQ) Prior plan—The terms and conditions of a plan in effect for the period preceding coverage in the MCHCP;

(RR) Provider—Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions and administrative guidelines of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized;

(SS) Review agency—A company responsible for administration of clinical management programs;

(TT) Second opinion program—A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service;

(UU) Skilled nursing facility (SNF)—An institution which meets fully each of the following requirements:

1. It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board and twenty-four (24) hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;

2. It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and

3. A skilled nursing facility shall be deemed to include institutions meeting the criteria in subsection (1)(UU) of this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97);

(VV) State—Missouri;

(WW) Subscriber—The employee or member who elects coverage under the plan;

(XX) Survivor—A member who meets the requirements of 22 CSR 10-2.020(5)(A);

(YY) Unemancipated child(ren)—A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-three (23) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

1. Stepchild(ren);

2. Foster child(ren) for whom the employee is responsible for health care;

3. Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care;

4. Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator. Except for a disabled child(ren) as described in subsection (1)(HH) of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-three (23) (see 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-three (23)); and

5. Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan;

(ZZ) Usual, customary, and reasonable charge—

1. Usual—The fee a physician most frequently charges the majority of his/her patients for the same or similar services;

2. Customary—The range of fees charged in a geographic area by physicians of comparable skills and qualifications for the same performance of similar service;

3. Reasonable—The flexibility to take into account any unusual clinical circumstances involved in performing a particular service; and

4. A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the doctors for ninety percent (90%) of the procedures reported; and

(AAA) Vested subscriber—A member who meets the requirements of 22 CSR 10-2.020(5)(B).

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rule covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RESCISSION

22 CSR 10-2.020 Membership Agreement and Participation Period. This rule established the policy of the board of trustees in regard to the employee's membership agreement and membership period for participation in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded due to the filing of a new emergency and proposed rule.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rescission is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be registered immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 20, 2004, effective January 1, 2005, expires June 29, 2005.*

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rescission covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.020 Subscriber Agreement and General Membership Provisions

PURPOSE: This rule establishes the policy of the board of trustees in regard to the employee's membership agreement and membership period for participation in the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 20, 2004, effective January 1, 2005, expires June 29, 2005.*

(1) The participant's initial application, any subsequently accepted modifications to such application, and the plan document as adopted by the board along with duly executed amendments shall comprise the subscriber agreement between the participant and the Missouri Consolidated Health Care Plan (MCHCP). Any associated administrative guidelines interpret the subscriber agreement for the benefit of members and administrators but are not a part of the subscriber agreement.

(A) By applying for coverage under the MCHCP a participant agrees that—

1. The employer may deduct the cost of the premium for the employee's plan from the employee's paychecks;

2. Individual and family deductibles, if appropriate, will be applied; and

3. Any individual eligible as an employee shall not be covered as a dependent unless the employee is on an approved leave of absence.

(2) The effective date of participation shall be determined, subject to the effective date provision in subsection (2)(C), as follows:

(A) Employee Participation.

1. If application by an employee is made on or before the date of eligibility, participation shall become effective on such date of eligibility;

2. If application by an employee is made within thirty-one (31) days after the date of eligibility, participation may become effective on the date of eligibility or the first day of the calendar month coinciding with or following the date of application, except that participation shall be retroactive to the beginning of the month for employees rehired during the month following the month participation would have terminated; and

3. Not limiting or excluding any of the other provisions, if application is not made within thirty-one (31) days of the employee's date of eligibility, they may apply for coverage only if a life event occurs. Life events include: marriage, birth, adoption, death, divorce, legal separation, job loss or failure to elect continuation of coverage. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event;

(B) Dependent Coverage. Dependent participation cannot precede the subscriber's participation. Application for participants must be made in accordance with the following provisions. For family coverage, once a subscriber is participating with respect to dependents, newly acquired dependents are automatically covered on their effective dates as long as the plan administrator is notified within thirty-one (31) days of the person becoming a dependent. First eligible dependents must be added within thirty-one (31) days of such qualifying event. The employee is required to notify the plan administrator on the appropriate form of the dependent's name, date of birth, eligibility date and Social Security number, if available. Claims will not be processed until the required information is provided.

1. If an employee makes concurrent application for dependent participation on or before the date of eligibility or within thirty-one (31) days thereafter, participation for dependent will become effective on the date the employee's participation becomes effective;

2. When an employee participating in the plan first becomes eligible with respect to a dependent child(ren), coverage may become effective on the eligibility date or the first day of the month coinciding with or following the date of eligibility if application is made within thirty-one (31) days of the date of eligibility and provided any required contribution for the period is made;

3. Unless required under federal guidelines—

A. An emancipated dependent who regains his/her dependent status is immediately eligible for coverage if an application is submitted within thirty-one (31) days of regaining dependent status; and

B. An eligible dependent that is covered under a spouse's health plan who loses eligibility under the criteria stipulated for dependent status under the spouse's health plan is not eligible for coverage until the next open enrollment period. (Note: Subparagraphs (2)(B)3.A. and B. do not include dependents of retirees or long-term disability members covered under the plan); and

4. Survivors, retirees, vested subscribers and long-term disability subscribers may only add dependents to their coverage when the dependent is first eligible for coverage;

(C) Effective Date Proviso.

1. In any instance when the employee is not actively working full-time on the date participation would otherwise have become effective, participation shall not become effective until the date the employee returns to full-time active work;

(D) Application for dependent coverage may be made at other times of the year when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's: 1) employment is terminated or is no longer eligible for coverage under his/her employer's plan, or 2) employer-sponsored medical plan is terminated. With respect to dependent child(ren) coverage, application may also be made at other times of the year when the member receives a court order stating s/he is responsible for providing medical coverage for the dependent child(ren) or when the dependent loses Medicaid coverage. Dependents added under any of these exceptions must supply verification from the previous insurance carrier or the member's employer that they have lost coverage and the effective date of termination. Coverage must also be requested within sixty (60) days from the termination date of the previous coverage. Application must be made within sixty (60) days of the court order. (Note: This section does not include dependents of retirees, survivors, vested subscribers, or long-term disability subscribers covered under the plan);

(E) When an employee experiences applicable life events, eligibility will be administered according to Health Insurance Portability and Accountability Act (HIPAA) guidelines.

(3) Termination of participation shall occur on the last day of the calendar month coinciding with or following the happening of any of the following events, whichever shall occur first:

(A) Written request by the employee;

(B) Failure to make any required contribution toward the cost of coverage;

(C) Entry into the armed forces of any country. With respect to an employee, membership in the National Guard or Reserves with or without two (2) consecutive full weeks of active training each year shall not be considered as entry into the armed forces; or

(D) Termination of Eligibility for Participation.

1. With respect to employees, termination of participation shall occur upon termination of employment in a position covered by the MCHCP, except as specified in sections (4) and (5).

2. With respect to dependents, termination of participation shall occur upon ceasing to be a dependent as defined in this rule with the following exception: unemancipated mentally retarded and/or physically handicapped children will continue to be eligible beyond age twenty-three (23) during the continuance of a permanent disability provided documentation satisfactory to the plan administrator is furnished by a physician prior to the dependent's twenty-third birthday, and as requested at the discretion of the plan administrator.

3. Termination of employee's participation shall terminate the participation of dependents, except as specified in section (5).

(4) Termination of participation shall occur immediately upon discontinuance of the plan subject to the plan termination provision specified in 22 CSR 10-2.080(1).

(5) Continuation of Coverage.

(A) Dependents. Termination of an active employee's participation by reason of death shall not terminate participation with respect to the surviving spouse and/or dependent children if—

1. The active employee was vested and eligible for a future retirement benefit; or

2. Your eligible dependents meet one (1) of the following conditions:

A. They have had coverage through MCHCP since the effective date of the last open enrollment period;

B. They have had other health insurance for the six (6) months immediately prior to your death—proof of insurance is required; or

C. They have had coverage through MCHCP since they were first eligible.

(B) Employee Eligible for Retirement Benefits. Any employee who, at the time of termination of employment, met the following—

1. Eligibility criteria:

A. Coverage through MCHCP since the effective date of the last open enrollment period;

B. Other health insurance for the six (6) months immediately prior to the termination of state employment—proof of insurance is required; or

C. Coverage since first eligible;

2. Immediately eligible to receive a monthly retirement benefit from the Missouri State Employees' Retirement System, Public School Retirement System, the retirement system of a participating public entity, or the Highway Retirement System may elect to continue to participate in the plan by paying the cost of plan benefits as determined by the plan administrator. An employee must apply for continued coverage within thirty-one (31) days of the first day of the month following the date of retirement. An employee, continuing coverage under this provision, may also continue coverage for eligible dependents.

A. If a member participates in the MCHCP as a vested member, his/her dependents may also participate if they meet one (1) of the following criteria:

(I) They have had coverage through MCHCP since the effective date of the last open enrollment period;

(II) They have had other health insurance for the six (6) months immediately prior to state employment termination—proof of insurance is required; or

(III) They have had coverage since they were first eligible;

3. In the case of the death of a retiree who was maintaining dependent coverage under this provision, the dependent of the deceased retiree may continue his/her participation under the plan. However, retirees, survivors, vested subscribers and long-term disability subscribers and their dependents are not later eligible if they discontinue their coverage at some future time, except as noted in (5)(B)4.; and

4. A vested or retired member may elect to suspend their coverage upon entry into the armed forces of any country by submitting a copy of their activation papers within thirty-one (31) days of their activation date. Coverage will be suspended the first of the month following the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of their separation papers and a completed enrollment form within thirty-one (31) days of their separation date. Coverage will be reinstated as of the first of the month following the month of separation.

(C) Coverage at Termination. A former employee may participate in the plan if s/he terminates employment before retirement provided s/he is a vested employee. This means s/he will be eligible for a benefit from the Missouri State Employees' Retirement System, the Public School Retirement System, the retirement system of a participating public entity or the Highway Retirement System when s/he reaches retirement age. Coverage may also be continued by a member of the general assembly, a state official holding a statewide elective office, or an employee employed by an elected state official or member of the general assembly whose employment is terminated because the state official or member of the general assembly ceases to hold elective office. The election to participate must be made within thirty-one (31) days from the last day of the month in which employment terminated. The member must pay the full cost of coverage. However, s/he will not later be eligible if s/he discontinues coverage at some future time.

(D) Leave of Absence. An employee on approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify the plan administrator of the leave of absence and any extension of the leave of absence by submitting the required form. Any employee on an approved leave of absence who was a member of the Missouri Consolidated Health Care Plan when the approved leave began, but who subsequently terminated participation in the Missouri Consolidated Health Care Plan while on leave, may recommence his/her coverage in the plan at the same level (employee only, or employee and dependents) upon returning to employment directly from the leave, but they will be subject to preexisting limitations, when applicable. Preexisting limitations under this provision will not apply to health maintenance organization (HMO) or point-of-service (POS) members. However, eligibility is terminated for those members receiving a military leave of absence, as specified in subsection (3)(C). Coverage may be reinstated upon return from military leave without proof of insurability or preexisting conditions. However, the former member must complete an enrollment form. Coverage under this provision is effective on the first of the month coinciding with or following the employee's return to work. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date and timely requests reinstatement of coverage.

(E) Layoff. An employee on layoff status may elect to retain eligibility to participate in the plan by paying the required contribution for a maximum of twenty-four (24) months with recertification of status at least every twelve (12) months by the employing department. Eligibility will terminate if the employee becomes eligible for health benefits as an employee of another employer. If participation terminates and the employee is recalled to service, eligibility will be as a new employee.

(F) Workers' Compensation. Any person who is receiving, or is entitled to receive, Workers' Compensation benefits as a result of an injury or accident sustained in employment and who was a member of the plan at the time of becoming disabled may continue his/her coverage in the plan at the same level of participation (employee only or employee and dependents) by paying the required contributions, if the disability occurred in the employment through which the employee qualifies for membership in the plan. Any person receiving, or entitled to receive, Workers' Compensation benefits who was a member of the plan at the time of becoming disabled as a result of an injury or accident sustained in employment through which the person qualified for membership in the plan, but who subsequently terminated participation in the plan, may recommence his/her coverage in the plan at the same level (employee only, or employee and dependents) upon returning to employment, without proving insurability.

(G) Reinstatement After Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action available as a recourse through his/her employer, s/he will be allowed to reinstate his/her medical benefit retroactively to the date of dismissal. If the employee is reinstated with back pay, s/he will be responsible for paying any contribution normally made for either his/her coverage or his/her covered dependents. No preexisting condition limitation will apply. If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making any required contribution toward the cost of his/her medical benefits. If the employee does not purchase coverage for the period between termination and reinstatement, s/he may regain the same level of coverage s/he had prior to termination. If the employee participates in a preferred provider organization (PPO) plan, the preexisting condition limitation will apply if coverage lapsed more than sixty-three (63) days. This does not apply if the employee participates in an HMO or POS.

(6) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) In accordance with the COBRA, eligible employees and their dependents may continue their medical coverage after the employee's termination date.

1. Employees terminating for reasons other than gross misconduct may continue coverage for themselves and their covered dependents for eighteen (18) months at their own expense.

2. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

3. A divorced spouse may continue coverage at his/her own expense for up to thirty-six (36) months if the plan administrator is notified within sixty (60) days from the date coverage would terminate.

4. Dependent spouse and/or child(ren) may continue coverage up to thirty-six (36) months if the covered employee retires and the dependent spouse/child(ren) has not been covered by the plan for two (2) years.

5. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense if the plan administrator is notified within sixty (60) days of the loss of the dependent's eligibility.

6. Employees who are disabled at termination or become disabled during the first sixty (60) days of coverage may continue coverage for up to twenty-nine (29) months.

7. Premiums for continued coverage will be one hundred two percent (102%) of the health plan rate, one hundred fifty percent (150%) if disabled. Once coverage is terminated under the COBRA provision it cannot be reinstated.

8. All operations under the COBRA provision will be applied in accordance with federal regulations.

(7) Missouri State Law COBRA Wrap-Around Provisions—Missouri law provides that if you lose your group health insurance coverage because of a divorce, legal separation or the death of your spouse you may continue coverage until age sixty-five (65) if: a) You continue and maintain coverage under the thirty-six (36)-month provision of COBRA; and b) You are at least fifty-five (55) years old when your COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay all of the application premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium. The above Cancellation of Continuation Coverage also applies to COBRA wrap-around continuation.

(8) Medicare—Participants eligible for Medicare who are not eligible for this plan as their primary plan, shall be eligible for benefits no less than those benefits for participants not eligible for Medicare. For such participants who elect to continue their coverage, benefits of this plan shall be coordinated with Medicare benefits on the then standard coordination of benefits basis to provide up to one hundred percent (100%) reimbursement for covered charges.

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, an estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim submitted basis so that if, for a given claim, Medicare reimbursement was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims; and

(B) If any retired participants or long-term disability recipients, their eligible dependents or surviving dependents eligible for coverage elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RESCISSION

22 CSR 10-2.030 Contributions. This rule established the policy of the board of trustees in regard to the contributions made to the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded due to the filing of a new emergency and proposed rule.

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rescission is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be registered immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 20, 2004, effective January 1, 2005, expires June 29, 2005.*

*AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.030 Contributions

PURPOSE: This rule establishes the policy of the board of trustees in regard to the contributions made to the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability

*and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 20, 2004, effective January 1, 2005, expires June 29, 2005.*

(1) Total premium costs for various classes of employee participation based on employment status, eligibility for Medicare and for various classifications of dependent participation are established by the plan administrator.

(2) The contribution by the employee shall be determined by the plan administrator for state employees.

(3) Refunds of overpayments are limited to the amount overpaid during the twelve (12)-month period ending at the end of the month preceding the month during which notice of overpayment is received.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June* 29, 2005. *A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RESCISSION

22 CSR 10-2.045 Co-Pay and PPO Plan Summaries. *This rule established the policy of the board of trustees in regard to the medical benefits for participation in the Missouri Consolidated Health Care Plan Co-Pay Plan.*

PURPOSE: This rule is being rescinded due to the filing of a new emergency and proposed rule.

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rescission is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be registered immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 20, 2004, effective January 1, 2005, expires June 29, 2005.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.045 Plan Utilization Review Policy

PURPOSE: This rule establishes the policy of the board of trustees in regard to the utilization review of the Missouri Consolidated Health Care Plan Medical Plans.

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 20, 2004, effective January 1, 2005, expires June 29, 2005.*

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program consists of four (4) parts, as described in the following:

(A) Precertification—The medical necessity of a non-emergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate review agency. For emergency hospital admissions, the review agency must be notified within forty-eight (48) hours of the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(B) Concurrent Review—The review agency will continue to monitor the medical necessity of the admission and approve the

continued stay in the hospital. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(C) Large Case Management—Members that require long-term acute care may be offered the option of receiving the care, if appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases this may require coverage for benefits that normally are not covered under the plan. These benefits may be provided through the approval of the claims administrator;

(D) Hospital Bill Audits—Certain hospital bills will be subject to review to verify that the services billed were actually provided and/or the associated billed amounts are accurate and appropriate; and

(E) Penalties—Members not complying with subsections (1)(A) and (B) of this rule may be subject to a financial penalty in connection with their covered benefits. (Note: The utilization review program will be operated in accordance with the administrative guidelines.)

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rule covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RESCISSION

22 CSR 10-2.055 Co-Pay and PPO Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan Co-Pay Plan.

PURPOSE: This rule is being rescinded due to the filing of a new emergency and proposed rule.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rescission is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be registered immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 20, 2004, effective January 1, 2005, expires June 29, 2005.*

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rescission covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan Co-Pay Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 20, 2004, effective January 1, 2005, expires June 29, 2005.*

(1) Benefit Provisions.

(A) Subject to the plan provisions and limitations and the written application of the employee, the benefits are payable for covered charges incurred by a participant while covered under the co-pay or PPO plan, provided the deductible requirement, if any, is met.

(B) Any deductible requirement applies each calendar year to covered charges. The requirement is met as soon as covered charges incurred in a calendar year, which are not paid in part or in whole by the plan, equals the deductible amount.

(C) Any family deductible requirement is met as soon as covered charges in a calendar year, which are not paid in part or in whole by the plan, equals the family deductible requirement.

(D) The total amount of benefits payable for all covered charges incurred out-of-network during an individual's lifetime shall not exceed the lifetime maximum.

(E) If both husband and wife are participating separately as employees under this plan, the family deductible and benefit features shall nevertheless apply to the benefit of the family unit.

(2) Covered Charges.

(A) Only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a noncovered service, and which are:

1. Prescribed by a doctor or provider for the therapeutic treatment of injury or sickness;

2. To the extent they do not exceed any limitation;

3. Not excluded by the limitations; and

4. For not more than the usual, reasonable, and customary charge as determined by the claims administrator for the services provided, will be considered covered charges.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, reasonable, and customary, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and

2. The usual, reasonable, and customary charges in the area in which services and/or supplies are provided.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rule covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RESCISSION

22 CSR 10-2.070 Coordination of Benefits. This rule established the policy of the board of trustees in regard to coordination of benefits in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded due to the filing of a new emergency and proposed rule.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rescission is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be registered immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 20, 2004, effective January 1, 2005, expires June 29, 2005.*

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rescission covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.070 Coordination of Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to coordination of benefits in the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 20, 2004, effective January 1, 2005, expires June 29, 2005.*

(1) If a participant is also covered under any other plan (as defined here) and is entitled to benefits or other services for which benefits are payable under this plan, the benefits under this plan will be adjusted as shown in this rule.

(2) As used in this rule—

(A) Plan means a plan listed in the following which provides medical, vision, dental or other health benefits or services:

1. A group or blanket plan on an insured basis;

2. Other plan which covers people as a group;

3. A self-insured or non-insured plan or other plan which is arranged through an employer, trustee or union;

4. A prepayment group plan which provides medical, vision, dental or health service;

5. Government plans, including Medicare;

6. Auto insurance when permitted by the laws of the state of jurisdiction; and

7. Single- or family-subscribed plans issued under a group- or blanket-type plan;

(B) The definition of plan shall not include:

1. Hospital preferred provider organization (PPO) type plans;

2. Types of plans for students; or

3. Any individual policy or plan;

(C) Each plan, as defined previously, is a separate plan. However, if only a part of the plan reserves the right to adjust its benefits due to other coverage, the portion of the plan which reserves the right and the portion which does not shall be treated as separate plans;

(D) Allowable expense means a necessary, reasonable and customary item of medical, vision, dental or health expense which is covered at least in part under one of the plans. If a plan provides benefits in the form of services, the cash value of such service will be deemed to be the benefit paid. An allowable expense to a secondary plan includes the value or amount of any allowable expense which was not paid by the primary or first paying plan; and

(E) Benefit determination period means from January 1 of one year through December 31 of the same year.

(3) The benefits under the policy shall be subject to the following:

(A) This provision shall apply in determining the benefit as to a person covered under the policy for a benefit determination period if the sum of paragraphs (3)(A)1. and 2. listed in this rule exceeds the allowable expense incurred by or on behalf of such person during the period—

1. The benefits payable under this plan in the absence of this provision; and

2. The benefits payable under all other plans in the absence of provisions similar to this one;

(B) As to any benefit determination period, the allowable expense under this plan shall be coordinated, except as provided in subsection (3)(C) of this rule, so that the sum of such benefits and all of the benefits paid, payable or furnished which relate to such allowable expense under other plans, shall not exceed the total of allowable expenses incurred by the covered individual. All benefits under other plans shall be taken into account whether or not claim has been made;

(C) If coverage under any other plan is involved, as shown in subsection (3)(B) of this rule—

1. This plan contains a provision coordinating benefits with other plans; and

2. The terms set forth in subsection (2)(D) would require benefits under this plan be figured before benefits under the other plan are figured, the benefits under this plan will be determined as though other plans were not involved;

(D) The basis for establishing the order in which plans determine benefits shall be as follows:

1. Benefits under the plan which cover the person on whom claim is based as an employee shall be determined before the benefits under a plan which cover the person as a dependent; and

2. The primary plan for dependent children will be the plan of the parent whose birthday occurs first in the calendar year. If both parents have the same birthday, the plan of the person who has been covered the longest period of time becomes the primary carrier:

A. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of the plan which covers the child as a dependent of the parent without custody;

B. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody; and

C. In spite of subparagraphs (3)(D)2.A. and B. of this rule, if there is a court decree which would otherwise decide financial duty for the medical, vision, dental or health care expenses for the child, the benefits of a plan which covers the child as a dependent of the parent with such financial duty shall be decided before the benefits of any other plan which covers the child as a dependent; and when paragraphs (3)(D)1. and 2. of this rule do not establish the order of benefit determination, the plan which covers the person for the longer time shall be determined first; and

(E) When this provision operates to reduce the benefits under this plan, each benefit that would have otherwise been paid will be reduced proportionately and this reduced amount shall be charged against the benefit limits of this plan.

(4) When a member has coverage with two (2) group plans, the plan which covers the person for the longer time shall be determined first.

(5) If a member is eligible for Medicare due to a disability, Medicare is the primary plan and this plan is a secondary plan. If a member or dependent is eligible for Medicare due to end stage renal disease, this plan is primary for the first thirty (30) months. Medicare is primary after the first thirty (30) months.

(6) The claims administrator, with the consent of the employee or the employee's spouse when the claim is for a spouse, or the parent or guardian when the claim is for a minor child, may release or obtain any data which is needed to implement this provision.

(7) When payments should have been paid under this plan but were already paid under some other plan, the claims administrator shall have the right to make payment to such other plan of the amount which would satisfy the intent of this provision. This payment shall discharge the liability under this plan.

(8) When payments made under this plan are in excess of the amount required to satisfy the intent of this provision, the claims administrator shall have the right to recover the excess payment from one (1) or more of the following:

(A) Any person to whom, for whom or with respect to whom these payments were made;

(B) Any insurance company; or

(C) Any other organization.

(9) The claims administrator will pay benefits promptly, or, if applicable, within their contractual time frame obligations after submittal of due proof of loss unless the claims administrator provides the claimant a clear, concise statement of a valid reason for further delay which is in no way connected with, or caused by the existence of this provision nor otherwise caused by the claims administrator.

(10) If one of the other plans involved (as defined in coordination of benefits provision) provides benefits on an excess insurance or excess coverage basis, subsections (3)(C) and (D) of this rule shall not apply to the plan and this policy will pay as excess coverage.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rule covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RESCISSION

22 CSR 10-2.075 Review and Appeals Procedure. This rule established the policy of the board of trustees in regard to review and appeals procedures for participation in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded due to the filing of a new emergency and proposed rule.

*EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rescission is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be registered immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 20, 2004, effective January 1, 2005, expires on June 29, 2005.*

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the **Code of State Regulations**. Emergency rescission filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rescission covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.075 Review and Appeals Procedure

PURPOSE: This rule establishes the policy of the board of trustees in regard to review and appeals procedures for participation in the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 20, 2004, effective January 1, 2005, expires June 29, 2005.*

(1) When any participant shall suffer any injury or sickness giving rise to claim under these rules, s/he shall have free choice of providers practicing legally in the location in which service is provided to the end that a provider/patient relationship shall be maintained. Reimbursement will be in accordance with the benefit provisions of the type of coverage chosen by the participant.

(2) The plan administrator, agent or claims administrator, upon receipt of a notice of request, shall furnish to the employee the forms as are usually furnished for filing proofs of loss. If the forms are not furnished within thirty (30) days after the giving of such notice, the employee shall be deemed to have complied with the requirement as to proof of loss upon submitting, within the time fixed for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which request is made.

(3) Written proof of claims incurred should be furnished to the claims administrator as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the claims administrator before they are paid.

(4) In the case of medical benefits, the claims administrator will send written notice of any amount applied toward the deductible as well as any payments made. The claims administrator may also send a request for additional information or material to support the claim, along with reasons why this information is necessary.

(5) All members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the health maintenance organization (HMO), point-of-service (POS), preferred provider organization (PPO) or co-pay health plan contractor or claims administrator applicable to the member. Only after these procedures have been exhausted may the member appeal directly to the Missouri Consolidated Health Care Plan Board of Trustees to review the decision of the health plan contractor or claims administrator.

(A) Appeals to the board of trustees shall be submitted in writing within forty-five (45) days of receiving the final decision from the member's health care plan contractor or claims administrator, specifically identifying the issue to be resolved and be addressed to:

Attn: Appeal
Board of Trustees
Missouri Consolidated Health Care Plan
PO Box 104355
Jefferson City, MO 65110

(B) The board may utilize a hearing officer, such as the Administrative Hearing Commission, to conduct a fact-finding hearing, and make proposed findings of fact and conclusions of law.

1. The hearing will be scheduled by the MCHCP.

2. The parties to the hearing will be the insured and the applicable health plan.

3. All parties shall be notified in writing of the date, time and location of the hearing.

4. All parties shall have the right to appear at the hearing and submit written or oral evidence. The appealing party shall be responsible for all copy charges incurred by MCHCP in connection with any documentation that must be obtained through the MCHCP. These fees will be reimbursed should the party prevail in his/her appeal. They may cross-examine witnesses. They need not appear and may still offer written evidence. The strict rules of evidence shall not apply.

5. The party appealing to the board shall carry the burden of proof.

6. The independent hearing officer shall propose findings of fact and conclusions of law, along with its recommendation, to the board. Copies of the summary, findings, conclusions and recommendations shall be sent to all parties.

(C) The board may, but is not required, to review the transcript of the hearing. It will review the summary of evidence, the proposed findings of fact and conclusions of law and shall then issue its final decision on the matter.

1. All parties shall be given a written copy of the board's final decision.

2. All parties shall be notified that if they feel aggrieved by the final decision, they shall have the right to seek judicial review of the decision within thirty (30) days of its receipt, as provided in sections 536.100 to 536.140, RSMo.

(D) Administrative decisions made solely by MCHCP may be appealed directly to the board of trustees, by either a member or health plan contractor providing a fully-insured product.

1. All the provisions of this rule, where applicable, shall apply to these appeals.

2. The parties to such appeal shall be the appellant and the MCHCP shall be respondent.

3. The appellant, if aggrieved by the final decision of the board, shall have the right of appeal as stated in subsection (5)(C) herein.

4. In reviewing these appeals, the board and/or staff may consider:

A. Newborns—

(I) Notwithstanding any other rule, if a member currently has children coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within six (6) months of the child's date of birth. If a member does not currently have children coverage under the plan but states that the required information was provided within the thirty-one (31)-day enrollment period, he/she must sign an affidavit stating that their information was provided within the required time period. The affidavit must be notarized and received in the MCHCP office within thirty-one (31) days after the date of notification from the MCHCP; and

(II) Once the MCHCP receives the signed affidavit from the member, coverage for the newborn will be backdated to the date of birth, if the request was made within six (6) months of the child's date of birth. The approval notification will include language that the MCHCP has no contractual authority to require the contractors to pay for claims that are denied due to the retroactive effective date. If an enrollment request is made under either of these two (2) scenarios past six (6) months following a child's date of birth, the information will be forwarded to the MCHCP board for a decision.

B. Credible evidence—Notwithstanding any other rule, the MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office or the MCHCP, that was no fault of the member.

C. Change of plans due to dependent change of address—A member may change plans outside the open enrollment period if his/her covered dependents move out of state and their current plan cannot provide coverage.

(E) Any member wishing to appeal their enrollment selection completed during the annual open enrollment period must do so in writing to the board of trustees within thirty (30) calendar days of the beginning of the new plan year. The MCHCP will respond within thirty (30) calendar days of the receipt of the appeal.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rule covering this same material is published in this issue of the* ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

EMERGENCY RESCISSION

22 CSR 10-2.080 Miscellaneous Provisions. This rule established the policy of the board of trustees in regard to miscellaneous provisions under the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded due to the filing of a new emergency and proposed rule.

EMERGENCY STATEMENT: This emergency rescission must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rescission is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rescission be registered immediately in order to maintain the integrity of the current health care plan. This emergency rescission must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rescission reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rescission complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rescission filed December 20, 2004, becomes effective January 1, 2005, expires June 29, 2005.*

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State***

Regulations. *Emergency rescission filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rescission covering this same material is published in this issue of the* ***Missouri Register***.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

EMERGENCY RULE

22 CSR 10-2.080 Miscellaneous Provisions

PURPOSE: This rule establishes the policy of the board of trustees in regard to miscellaneous provisions under the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 20, 2004, effective January 1, 2005, expires June 29, 2005.*

(1) Termination of the Plan. Any other provision of this plan to the contrary notwithstanding, no benefit will be paid for charges incurred by a participant or former participant after the termination of this plan.

(2) Facility of Payment. Plan benefits will be paid to the employee if living and capable of giving a valid release for the payment due. If the participant, while living, is physically, mentally or for any other reason incapable of giving a valid release for any payment due, the claims administrator at his/her option, unless and until request is made by the duly appointed guardian, may pay benefits which may become due to any blood relative or relative connected by marriage to the participant, or to any other person or institution appearing to the claims administrator to have assumed responsibility for the affairs of the participant. Any payments made by the claims administrator in good faith pursuant to this provision shall fully discharge the claims administrator to the extent of the payment. Any benefit unpaid at the time of the employee's death will be paid to the employee's estate. If any benefits shall be payable to the estate of the employee, the claims administrator may pay these benefits to any relative by blood or connection by marriage of the employee who is deemed by the claims administrator to be equitably entitled to it. Any payments made by the claims administrator in good faith pursuant to this provision shall fully discharge the claims administrator to the extent of this payment. Subject to any acceptable written direction and assignment by the employee, any benefits provided, at the claims administrator's option, may be paid directly to an eligible provider rendering covered services; but it is not required that the service be rendered by a particular provider.

(3) Confidentiality of Records. The health records of the participants in the plan are confidential and shall not be disclosed to any person, except pursuant to a written request by, or with the prior written consent of, the individual to whom the records pertain, unless disclosure of the records would be to the officers and employees of the plan or claims administrator or his/her legal representatives who have a need for the records in the performance of their duties; or unless disclosure would be for a routine use by the plan or claims administrator for a purpose which is compatible with the purpose for which it was collected; or unless disclosure of the records would be to the commissioner of administration, or his/her legal representative, for the sole purpose of preventing fraudulent or redundant medical claims to either the Missouri Consolidated Health Care Plan, Missouri, or other public entities as an employer or self-insurer of Workers' Compensation for use in the investigation of a Workers' Compensation claim; or unless disclosure of the records is to the participant to whom the record pertains; or unless disclosure of the record is pursuant to the order of a court of competent jurisdiction. The parent of any minor, or the legal guardian of any individual who has been declared to be incompetent due to physical or mental incapacity by a court of competent jurisdiction, may act on behalf of the individual.

(4) Should any provision of this plan conflict with the requirements of federal or state law, including but not limited to the Health Insurance Portability and Accountability Act, Family and Medical Leave Act, the Americans with Disabilities Act or the Older Workers Benefit Protection Act, the plan shall be administered in such a way as to comply with the requirements of law, and will be deemed amended to conform with law.

(5) This document will be kept on file at the principal offices of the plan administrator and may be inspected by a participant during regular business hours. Also, the plan administrator reserves the right at any time to modify or amend, in whole or in part, any or all provisions of the plan.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations***. *Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rule covering this same material is published in this issue of the* ***Missouri Register***.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.010 Definitions

PURPOSE: This rule establishes the policy of the board of trustees regarding the key terms within the Missouri Consolidated Health Care Plan relative to public entities and public entity members.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated

Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 20, 2004, becomes effective January 1, 2005, and expires June 29, 2005.*

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) When used in this chapter's rules or the public entity member handbook, these words and phrases have the meaning—

(A) Accident—An unexpected happening resulting in an injury which is not due to any fault or misconduct on the part of the person injured;

(B) Actively at work—You are considered actively at work when performing in the customary manner all of the regular duties of your occupation with the employer either at one (1) of the employer's regular places of business or at some location which the employer's business requires you to travel to perform your regular duties or other duties assigned by your employer. You are also considered to be actively at work on each day of a regular paid vacation or nonworking day on which you are not totally disabled, but only if you are performing in the customary manner all of the regular duties of your occupation with the employer on the immediately preceding regularly scheduled workday;

(C) Administrative guidelines—The interpretation of the plan document as approved by the plan administrator, developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered;

(D) Automatic reinstatement maximum—The maximum annual amount that can be reinstated to an individual's lifetime benefit;

(E) Benefit year—The twelve (12)-month period beginning January 1 and ending December 31;

(F) Benefits—Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator;

(G) Care Support Program—A voluntary program that helps manage a chronic condition with outpatient treatment;

(H) Claims administrator—An organization or group responsible for the processing of claims and associated services for the plan's self-insured benefit programs and preferred provider organization (PPO);

(I) Cosmetic surgery—A procedure performed primarily to preserve or improve appearance rather than restore the anatomy and/or function of the body which are lost or impaired due to illness or injury;

(J) Covered benefits—A schedule of covered services and charges, including chiropractic services, which are payable under the plan;

(K) Custodial care—Care designed essentially to assist an individual to meet the activities of daily living; for example, assistance in bathing, supervision of medication which can usually be self-administered and which does not entail or require the continuing attention of trained medical or paramedical personnel;

(L) Dependent-only participation—Participation of certain survivors of employees. Dependent participation may be further defined to include the deceased employee's: 1) spouse only; 2) child(ren) only; or 3) spouse and child(ren);

(M) Dependents—The lawful spouse of the employee, the employee's unemancipated child(ren) and certain survivors of employees, as provided in the plan document and these rules, for whom application has been made and has been accepted for participation in the plan;

(N) Eligibility date—Refer to 22 CSR 10-3.020 for effective date provisions.

1. Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of eligibility as determined by the employer.

(O) Emancipated child(ren)—A child(ren) who is—

1. Employed on a full-time basis;

2. Eligible for group health benefits in his/her own behalf;

3. Maintaining a residence separate from his/her parents or guardian—except for full-time students in an accredited school or institution of higher learning; or

4. Married;

(P) Employee and dependent participation—Participation of an employee and the employee's eligible dependents. Dependent participation may be further defined to include the participating employee's: 1) spouse only; 2) child(ren) only; or 3) spouse and child(ren). Any individual eligible for participation as an employee is not eligible as a dependent, except as noted in 22 CSR 10-3.030(1)(A)9.;

(Q) Employee only participation—Participation of an employee without participation of the employee's dependents, whether or not the employee has dependents;

(R) Employees—Employees of the participating public entity and present and future retirees from the participating public entity who meet the eligibility requirements as prescribed by the participating public entity;

(S) Employer—The public entity that employs the eligible employee as defined above;

(T) Executive director—The administrator of the Missouri Consolidated Health Care Plan (MCHCP) who reports directly to the plan administrator;

(U) Health maintenance organization (HMO)—An organization that provides for a wide range of comprehensive health care services for a specified group at a fixed periodic prepayment;

(V) Home health agency—An agency certified by the Missouri Department of Health and Senior Services, or any other state's licensing or certifying body, to provide health care services to persons in their homes;

(W) Hospice—A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill;

(X) Hospital.

1. An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24) hour-a-day nursing service by a registered nurse (RN) on duty or call.

2. An institution not meeting all the requirements of (1)(X)1. of this rule, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

3. An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).

4. A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

5. A residential alcoholism, chemical dependency or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction. In no event shall the term hospital include a skilled nursing facility or any institution or part thereof which is used primarily as a skilled nursing facility, nursing home, rest home or facility for the aged;

(Y) Lifetime—The period of time you or your eligible dependents participate in the plan;

(Z) Medical benefits coverage—Services that are received from providers recognized by the plan and are covered benefits under the plan;

(AA) Medically necessary—Services and/or supplies usually rendered or prescribed for the specific illness or injury;

(BB) Nurse—A registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule;

(CC) Open enrollment period—A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year;

(DD) Out-of-area—Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria;

(EE) Out-of-network—Providers that do not participate in the member's health plan;

(FF) Participant—Any employee or dependent accepted for membership in the plan;

(GG) Physically or mentally disabled—The inability of a person to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition;

(HH) Physician/Doctor—A licensed practitioner of the healing arts, acting within the scope of his/her practice as licensed under 334.021, RSMo;

(II) Plan—The program of health care benefits established by the trustees of the Missouri Consolidated Health Care Plan as authorized by state law;

(JJ) Plan administrator—The trustees of the Missouri Consolidated Health Care Plan;

(KK) Plan document—The statement of the terms and conditions of the plan as adopted by the plan administrator in the "2005 Missouri Consolidated Health Care Plan Public Entity Employee Member Handbook" with respect to dental and vision coverage and incorporated by reference in this rule, as published in August, 2004 by the Missouri Consolidated Health Care Plan, PO Box 104355, Jefferson City, MO 65110. This rule does not incorporate any subsequent amendments or additions. Note: The plan documents for medical plans are provided by the fully-insured contractors of such plans, and such plan documents may be obtained by contacting those contractors directly. The names, addresses, and phone numbers of the fully-insured contractors may be found in the "2005 Missouri Consolidated Health Care Plan Public Entity Employee Member Handbook;"

(LL) Plan year—Same as benefit year;

(MM) Point-of-service (POS)—A plan which provides a wide range of comprehensive health care services, like an HMO, if in-network providers are utilized, and like a PPO plan, if non-network providers are utilized;

(NN) Pre-admission testing—X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission;

(OO) Preferred provider organization (PPO)—An arrangement with providers where discounted rates are given to members of the plan who, in turn, are offered a financial incentive to use these providers;

(PP) Prior plan—The terms and conditions of a plan in effect for the period preceding coverage in the MCHCP;

(QQ) Provider—Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions and administrative guidelines of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized;

(RR) Public entity—A state-sponsored institution of higher learning, political subdivision or governmental entity or instrumentality that has elected to join the plan and has been accepted by the board;

(SS) Review agency—A company responsible for administration of clinical management programs;

(TT) Second opinion program—A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service;

(UU) Skilled nursing facility (SNF)—An institution which meets fully each of the following requirements:

1. It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board and twenty-four (24) hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;

2. It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and

3. A skilled nursing facility shall be deemed to include institutions meeting the criteria in subsection (1)(UU) of this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97);

(VV) State—Missouri;

(WW) Subscriber—The employee or member who elects coverage under the plan;

(XX) Survivor—A member who meets the requirements of 22 CSR 10-3.020(6)(A);

(YY) Unemancipated child(ren)—A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-three (23) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

1. Stepchild(ren);

2. Foster child(ren) for whom the employee is responsible for health care;

3. Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care;

4. Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator. Except for a disabled child(ren) as described in subsection (1)(GG) of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-three (23) (twenty-five (25) if attending school full-time and the public entity joining the plan had immediate previous coverage allowing this provision) (see 22 CSR 10-3.020(4)(D)2. for

continuing coverage on a handicapped child(ren) beyond age twenty-three (23)); and

5. Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan;

(ZZ) Usual, customary, and reasonable charge—

1. Usual—The fee a physician most frequently charges the majority of his/her patients for the same or similar services;

2. Customary—The range of fees charged in a geographic area by physicians of comparable skills and qualifications for the same performance of similar service;

3. Reasonable—The flexibility to take into account any unusual clinical circumstances involved in performing a particular service; and

4. A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the doctors for ninety percent (90%) of the procedures reported; and

(AAA) Vested subscriber—A member who meets the requirements of 22 CSR 10-3.020(6)(B).

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.020 Subscriber Agreement and General Membership Provisions

PURPOSE: This rule establishes the policy of the board of trustees in regard to the employee's subscriber agreement and membership period for participation in the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 20, 2004, effective January 1, 2005, expires June 29, 2005.*

(1) The participant's initial application, any subsequently accepted modifications to such application, and the plan document as adopted by the board along with duly executed amendments shall comprise the subscriber agreement between the participant and the Missouri Consolidated Health Care Plan (MCHCP). Any associated administrative guidelines interpret the subscriber agreement for the benefit of members and administrators but are not part of the subscriber agreement.

(A) By applying for coverage under the MCHCP a participant agrees that—

1. The employer may deduct the cost of the premium for the employee's plan from the employee's paychecks; and

2. Individual and family deductibles, if appropriate, will be applied. Deductibles previously paid to meet the requirements of the prior plan may be credited for those joining one of the preferred provider organization (PPO) options. Appropriate proof of said deductibles will be required.

(2) The participation period shall begin on the participant's effective date in the plan. Participation shall continue until this plan or coverage in this rule is terminated for any reason. However, transfer from the prior plan to this plan will be automatic upon the effective date of this plan.

(3) The effective date of participation shall be determined, subject to the effective date provision in subsection (3)(C), as follows:

(A) Employee Participation.

1. If application by an employee is made on or before the date of eligibility, participation shall become effective on such date of eligibility;

2. If application by an employee is made within thirty-one (31) days after the date of eligibility, participation may become effective on the date of eligibility or the first day of the calendar month coinciding with or following the date of application, except that participation shall be retroactive to the beginning of the month for employees rehired during the month following the month participation would have terminated; and

3. Not limiting or excluding any of the other provisions, if application is not made within thirty-one (31) days of the employee's date of eligibility, they may apply for coverage only if a life event occurs. Life events include: marriage, birth, adoption, death, divorce, legal separation, job loss or failure to elect continuation of coverage. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event;

(B) Dependent Coverage. Dependent participation cannot precede the subscriber's participation. Application for participants must be made in accordance with the following provisions. For family coverage, once a subscriber is participating with respect to dependents, newly acquired dependents are automatically covered on their effective dates as long as the plan administrator is notified within thirty-one (31) days of the person becoming a dependent. First eligible dependents must be added within thirty-one (31) days of such qualifying event. The employee is required to notify the plan administrator on the appropriate form of the dependent's name, date of birth, eligibility date and Social Security number, if available. Claims will not be processed until the required information is provided.

1. If an employee makes concurrent application for dependent participation on or before the date of eligibility or within thirty-one (31) days thereafter, participation for dependent will become effective on the date the employee's participation becomes effective;

2. When an employee participating in the plan first becomes eligible with respect to a dependent child(ren), coverage may become effective on the eligibility date or the first day of the month coinciding with or following the date of eligibility if application is made within thirty-one (31) days of the date of eligibility and provided any required contribution for the period is made;

3. Unless required under federal guidelines—

A. An emancipated dependent who regains his/her dependent status is immediately eligible for coverage if an application is submitted within thirty-one (31) days of regaining dependent status; and

B. An eligible dependent that is covered under a spouse's health plan who loses eligibility under the criteria stipulated for dependent status under the spouse's health plan is not eligible for coverage until the next open enrollment period. (Note: Subparagraphs (3)(B)3.A. and B. do not include dependents of retirees or long-term disability members covered under the plan); and

4. Survivors, retirees, vested subscribers and long-term disability subscribers may only add dependents to their coverage when the dependent is first eligible for coverage;

(C) Effective Date Proviso.

1. In any instance when the employee is not actively working full-time on the date participation would otherwise have become effective, participation shall not become effective until the date the employee returns to full-time active work. However, this provision shall not apply for public entities (or any individual who is a member of that public entity) when the MCHCP is replacing coverage for that public entity;

(D) Application for dependent coverage may be made at other times of the year when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's: 1) employment is terminated or is no longer eligible for coverage under his/her employer's plan, or 2) employer-sponsored medical plan is terminated. With respect to dependent child(ren) coverage, application may also be made at other times of the year when the member receives a court order stating s/he is responsible for providing medical coverage for the dependent child(ren) or when the dependent loses Medicaid coverage. Dependents added under any of these exceptions must supply verification from the previous insurance carrier or the member's employer that they have lost coverage and the effective date of termination. Coverage must also be requested within sixty (60) days from the termination date of the previous coverage. Application must be made within sixty (60) days of the court order. (Note: This section does not include dependents of retirees, survivors, vested subscribers, or long-term disability subscribers covered under the plan); and

(E) When an employee experiences applicable life events, eligibility will be administered according to Health Insurance Portability and Accountability Act (HIPAA) guidelines.

(4) Termination of participation shall occur on the last day of the calendar month coinciding with or following the happening of any of the following events, whichever shall occur first:

(A) Written request by the employee;

(B) Failure to make any required contribution toward the cost of coverage;

(C) Entry into the armed forces of any country. With respect to an employee, membership in the National Guard or Reserves with or without two (2) consecutive full weeks of active training each year shall not be considered as entry into the armed forces; or

(D) Termination of Eligibility for Participation.

1. With respect to employees, termination of participation shall occur upon termination of employment in a position covered by the MCHCP, except as specified in sections (5) and (6).

2. With respect to dependents, termination of participation shall occur upon ceasing to be a dependent as defined in this rule with the following exception: unemancipated mentally retarded and/or physically handicapped children will continue to be eligible beyond age twenty-three (23) during the continuance of a permanent disability provided documentation satisfactory to the plan administrator is furnished by a physician prior to the dependent's twenty-third birthday, and as requested at the discretion of the plan administrator.

3. Termination of employee's participation shall terminate the participation of dependents, except as specified in section (6).

(5) Termination of participation shall occur immediately upon discontinuance of the plan subject to the plan termination provision specified in 22 CSR 10-2.080(1).

(6) Continuation of Coverage.

(A) Dependents. Termination of an active employee's participation by reason of death shall not terminate participation with respect to the surviving spouse and/or dependent children if—

1. The active employee was vested and eligible for a future retirement benefit; or

2. Your eligible dependents meet one (1) of the following conditions:

A. They have had coverage through MCHCP since the effective date of the last open enrollment period;

B. They have had other health insurance for the six (6) months immediately prior to your death—proof of insurance is required; or

C. They have had coverage through MCHCP since they were first eligible.

(B) Employee Eligible for Retirement Benefits. Any employee who, at the time of termination of employment, met the following—

1. Eligibility Criteria:

A. Coverage through MCHCP since the effective date of the last open enrollment period;

B. Other health insurance for the six (6) months immediately prior to the termination of state employment—proof of insurance is required; or

C. Coverage since first eligible;

2. Immediately eligible to receive a monthly retirement benefit from the retirement system of the participating public entity may elect to continue to participate in the plan by paying the cost of plan benefits as determined by the plan administrator. An employee must apply for continued coverage within thirty-one (31) days of the first day of the month following the date of retirement. An employee, continuing coverage under this provision, may also continue coverage for eligible dependents.

A. If a member participates in the MCHCP as a vested member, his/her dependents may also participate if they meet one (1) of the following criteria:

(I) They have had coverage through MCHCP since the effective date of the last open enrollment period;

(II) They have had other health insurance for the six (6) months immediately prior to state employment termination—proof of insurance is required; or

(III) They have had coverage since they were first eligible;

3. In the case of the death of a retiree who was maintaining dependent coverage under this provision, the dependent of the deceased retiree may continue his/her participation under the plan. However, retirees, survivors, vested subscribers and long-term disability subscribers and their dependents are not later eligible if they discontinue their coverage at some future time, except as noted in (7)(B)4.; and

4. A vested or retired member may elect to suspend their coverage upon entry into the armed forces of any country by submitting a copy of their activation papers within thirty-one (31) days of their activation date. Coverage will be suspended the first of the month following the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of their separation papers and a completed enrollment form within thirty-one (31) days of their separation date. Coverage will be reinstated as of the first of the month following the month of separation.

(C) Coverage at Termination. A former employee may participate in the plan if s/he terminates employment before retirement provided s/he is a vested employee. This means s/he will be eligible for a benefit from the retirement system of the participating public entity when s/he reaches retirement age. The election to participate must be made within thirty-one (31) days from the last day of the month in which employment terminated. The member must pay the full

cost of coverage. However, s/he will not later be eligible if s/he discontinues coverage at some future time.

(D) Leave of Absence. An employee on approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify the plan administrator of the leave of absence and any extension of the leave of absence by submitting the required form. Any employee on an approved leave of absence who was a member of the Missouri Consolidated Health Care Plan when the approved leave began, but who subsequently terminated participation in the Missouri Consolidated Health Care Plan while on leave, may recommence his/her coverage in the plan at the same level (employee only, or employee and dependents) upon returning to employment directly from the leave, but they will be subject to preexisting limitations, when applicable. Preexisting limitations under this provision will not apply to health maintenance organization (HMO) or point-of-service (POS) members. However, eligibility is terminated for those members receiving a military leave of absence, as specified in subsection (5)(C). Coverage may be reinstated upon return from military leave without proof of insurability or preexisting conditions. However, the former member must complete an enrollment form. Coverage under this provision is effective on the first of the month coinciding with or following the employee's return to work. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date and timely requests reinstatement of coverage.

(E) Layoff. An employee on layoff status may elect to retain eligibility to participate in the plan by paying the required contribution for a maximum of twenty-four (24) months with recertification of status at least every twelve (12) months by the employing department. Eligibility will terminate if the employee becomes eligible for health benefits as an employee of another employer. If participation terminates and the employee is recalled to service, eligibility will be as a new employee.

(F) Workers' Compensation. Any person who is receiving, or is entitled to receive, Workers' Compensation benefits as a result of an injury or accident sustained in employment and who was a member of the plan at the time of becoming disabled may continue his/her coverage in the plan at the same level of participation (employee only or employee and dependents) by paying the required contributions, if the disability occurred in the employment through which the employee qualifies for membership in the plan. Any person receiving, or entitled to receive, Workers' Compensation benefits who was a member of the plan at the time of becoming disabled as a result of an injury or accident sustained in employment through which the person qualified for membership in the plan, but who subsequently terminated participation in the plan, may recommence his/her coverage in the plan at the same level (employee only, or employee and dependents) upon returning to employment, without proving insurability.

(G) Reinstatement After Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action available as a recourse through his/her employer, s/he will be allowed to reinstate his/her medical benefit retroactively to the date of dismissal. If the employee is reinstated with back pay, s/he will be responsible for paying any contribution normally made for either his/her coverage or his/her covered dependents. No preexisting condition limitation will apply. If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making any required contribution toward the cost of his/her medical benefits. If the employee does not purchase coverage for the period between termination and reinstatement, s/he may regain the same level of coverage s/he had prior to termination. If the employee participates in a PPO plan, the preexisting condition limitation will apply if coverage lapsed more than sixty-three (63) days. This does not apply if the employee participates in an HMO or POS.

(7) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) In accordance with the COBRA, eligible employees and their dependents may continue their medical coverage after the employee's termination date.

1. Employees terminating for reasons other than gross misconduct may continue coverage for themselves and their covered dependents for eighteen (18) months at their own expense.

2. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

3. A divorced spouse may continue coverage at his/her own expense for up to thirty-six (36) months if the plan administrator is notified within sixty (60) days from the date coverage would terminate.

4. Dependent spouse and/or child(ren) may continue coverage up to thirty-six (36) months if the covered employee retires and the dependent spouse/child(ren) has not been covered by the plan for two (2) years.

5. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense if the plan administrator is notified within sixty (60) days of the loss of the dependent's eligibility.

6. Employees who are disabled at termination or become disabled during the first sixty (60) days of coverage may continue coverage for up to twenty-nine (29) months.

7. Premiums for continued coverage will be one hundred two percent (102%) of the health plan rate, one hundred fifty percent (150%) if disabled. Once coverage is terminated under the COBRA provision it cannot be reinstated.

8. All operations under the COBRA provision will be applied in accordance with federal regulations.

(8) Missouri State Law COBRA Wrap-Around Provisions—Missouri law provides that if you lose your group health insurance coverage because of a divorce, legal separation or the death of your spouse you may continue coverage until age sixty-five (65) if: a) You continue and maintain coverage under the thirty-six (36)-month provision of COBRA; and b) You are at least fifty-five (55) years old when your COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay all of the application premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium. The above Cancellation of Continuation Coverage also applies to COBRA wrap-around continuation.

(9) Medicare—Participants eligible for Medicare who are not eligible for this plan as their primary plan, shall be eligible for benefits no less than those benefits for participants not eligible for Medicare. For such participants who elect to continue their coverage, benefits of this plan shall be coordinated with Medicare benefits on the then standard coordination of benefits basis to provide up to one hundred percent (100%) reimbursement for covered charges.

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, an estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim submitted basis so that if, for a given claim, Medicare reimbursement was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims; and

(B) If any retired participants or long-term disability recipients, their eligible dependents or surviving dependents eligible for coverage elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.030 Public Entity Membership Agreement and Participation Period

PURPOSE: This rule establishes the policy of the board of trustees in regard to the public entity's membership agreement and participation period with the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 20, 2004, effective January 1, 2005, expires June 29, 2005.*

(1) The application packet, participation agreement and confirmation notice shall comprise the membership agreement between a public entity and the Missouri Consolidated Health Care Plan (MCHCP).

(A) By applying for coverage under the MCHCP a public entity agrees that—

1. The MCHCP will be the only health care offering made to its eligible members;

2. If the public entity participated in the MCHCP during calendar year 2004 and continues to participate each year subsequent to calendar year 2004, that public entity shall only be required to contribute twenty-five dollars ($25) per month towards the employee only premium for each active employee's premium for the plan(s) offered through MCHCP during calendar years 2005 and 2006;

3. If the public entity did not participate in the MCHCP during calendar year 2004, that public entity shall contribute at least fifty percent (50%) of the lowest cost employee only premium per month toward each active employee's premium for the plan(s) offered through MCHCP;

4. Beginning January 1, 2007, all public entities shall contribute at least fifty percent (50%) of the lowest cost employee only premium per month toward each active employee's premium for the plan(s) offered through MCHCP;

5. For public entities with less than twenty-five (25) employees, the public entity shall only offer one (1) plan choice to its employees. For public entities with twenty-five (25) or more employees, the public entity may offer more than one (1) plan choice provided by MCHCP.

6. For public entities with more than a total of three (3) employees, at least seventy-five percent (75%) of all eligible employees must join the MCHCP. For public entities with three (3) or fewer employees, a minimum of one (1) employee must join the MCHCP. For public entities with three (3) or fewer employees who fail to have one (1) employee participating in the MCHCP, MCHCP will allow the public entity up to twelve (12) months in which to attempt to meet the participation requirements before terminating for failure to meet the participation requirements. Such a termination for those public entities with three (3) or fewer employees will occur retroactively to the date such participation requirement failed to be met;

7. Individual and family deductibles, if applicable, will be applied. Deductibles previously paid to meet the requirements of the terminating plan may be credited for those joining one of the PPO options. Appropriate proof of said deductibles will be required;

8. An eligible employee is one that is not covered by another group sponsored plan;

9. Any individual eligible as an employee may be covered as either an employee or dependent, but not both. Employees enrolled as dependents will not be considered as eligible employees in consideration of section (6); and

10. A public entity may apply a probationary period, not to exceed applicable federal guidelines, before benefits become effective.

(B) Effective January 1, 2001, in order to provide retiree coverage, any participating member agency joining MCHCP must have one of the criteria listed below. If neither of these scenarios is applicable and no retirement plan exists, no "retirees" would exist, so there would be no retiree eligibility.

1. An established retirement plan with contributions shared by both the employee and the employer (or made by the employer only) with an established minimum vesting period. The employer must offer coverage to retirees who have met this minimum vesting period requirement.

2. An employer-sponsored (but no contribution made by employer) retirement plan in which the employee is currently participating or from which the employee is eligible to receive a benefit. In this case, in order to be considered an eligible retiree, the prospective member must have met a vesting criterion equal to Missouri State Employees' Retirement System (MOSERS). If this criterion was not met, the employer may not offer coverage to that person as a retiree.

(2) The public entity's participation period shall begin on the date specified in the participation agreement. Participation shall continue until the end of the participation agreement is reached or immediately upon discontinuance of the plan subject to the plan termination provision specified in 22 CSR 10-3.080(1).

(3) The voluntariness of the public entity's failure to meet participation levels is to be determined by MCHCP. Examples of non-voluntary failure to meet participation levels include: 1) a public entity falls below the required participation level due to employment termination(s); and 2) a public entity falls below the required participation level, but the public entity can prove that all eligible employees who failed to take the coverage have other group coverage not offered through the public entity or are Medicare eligible.

(4) Total premium costs for various classes of employee participation based on employment status, eligibility for Medicare and for various classifications of dependent participation are established by the plan administrator.

(5) Underwriting guidelines are set by the plan administrator.

(6) The contribution by the employee shall be determined, within the underwriting guidelines set by the plan administrator, by the appropriate administrative unit for the public entity.

(7) Refunds of overpayments are limited to the amount overpaid during the twelve (12)-month period ending at the end of the month preceding the month during which notice of overpayment is received.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rule covering this same material is published in this issue of the **Missouri Register**.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.070 Coordination of Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to coordination of benefits in the Missouri Consolidated Health Care Plan.

*EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the **Missouri** and **United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 20, 2004, effective January 1, 2005, expires June 29, 2005.*

(1) If a participant is also covered under any other plan (as defined here) and is entitled to benefits or other services for which benefits are payable under this plan, the benefits under this plan will be adjusted as shown in this rule.

(2) As used in this rule—

(A) Plan means a plan listed in the following which provides medical, vision, dental or other health benefits or services:

1. A group or blanket plan on an insured basis;
2. Other plan which covers people as a group;
3. A self-insured or non-insured plan or other plan which is arranged through an employer, trustee or union;
4. A prepayment group plan which provides medical, vision, dental or health service;
5. Government plans, including Medicare;
6. Auto insurance when permitted by the laws of the state of jurisdiction; and
7. Single- or family-subscribed plans issued under a group- or blanket-type plan;

(B) The definition of plan shall not include:

1. Hospital preferred provider organization (PPO) type plans;
2. Types of plans for students; or
3. Any individual policy or plan;

(C) Each plan, as defined previously, is a separate plan. However, if only a part of the plan reserves the right to adjust its benefits due to other coverage, the portion of the plan which reserves the right and the portion which does not shall be treated as separate plans;

(D) Allowable expense means a necessary, reasonable and customary item of medical, vision, dental or health expense which is covered at least in part under one of the plans. If a plan provides benefits in the form of services, the cash value of such service will be deemed to be the benefit paid. An allowable expense to a secondary plan includes the value or amount of any allowable expense which was not paid by the primary or first paying plan; and

(E) Benefit determination period means from January 1 of one year through December 31 of the same year.

(3) The benefits under the policy shall be subject to the following:

(A) This provision shall apply in determining the benefit as to a person covered under the policy for a benefit determination period if the sum of paragraphs (3)(A)1. and 2. listed in this rule exceeds the allowable expense incurred by or on behalf of such person during the period—

1. The benefits payable under this plan in the absence of this provision; and
2. The benefits payable under all other plans in the absence of provisions similar to this one;

(B) As to any benefit determination period, the allowable expense under this plan shall be coordinated, except as provided in subsection (3)(C) of this rule, so that the sum of such benefits and all of the benefits paid, payable or furnished which relate to such allowable expense under other plans, shall not exceed the total of allowable expenses incurred by the covered individual. All benefits under other plans shall be taken into account whether or not claim has been made;

(C) If coverage under any other plan is involved, as shown in subsection (3)(B) of this rule—

1. This plan contains a provision coordinating benefits with other plans; and
2. The terms set forth in subsection (2)(D) would require benefits under this plan be figured before benefits under the other plan are figured, the benefits under this plan will be determined as though other plans were not involved;

(D) The basis for establishing the order in which plans determine benefits shall be as follows:

1. Benefits under the plan which cover the person on whom claim is based as an employee shall be determined before the benefits under a plan which cover the person as a dependent; and
2. The primary plan for dependent children will be the plan of the parent whose birthday occurs first in the calendar year. If both parents have the same birthday, the plan of the person who has been covered the longest period of time becomes the primary carrier:

A. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of the plan which covers the child as a dependent of the parent without custody;

B. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of

a plan which covers that child as a dependent of the parent without custody; and

C. In spite of subparagraphs (3)(D)2.A. and B. of this rule, if there is a court decree which would otherwise decide financial duty for the medical, vision, dental or health care expenses for the child, the benefits of a plan which covers the child as a dependent of the parent with such financial duty shall be decided before the benefits of any other plan which covers the child as a dependent; and when paragraphs (3)(D)1. and 2. of this rule do not establish the order of benefit determination, the plan which covers the person for the longer time shall be determined first; and

(E) When this provision operates to reduce the benefits under this plan, each benefit that would have otherwise been paid will be reduced proportionately and this reduced amount shall be charged against the benefit limits of this plan.

(4) When a member has coverage with two (2) group plans, the plan which covers the person for the longer time shall be determined first.

(5) If a member is eligible for Medicare due to a disability, Medicare is the primary plan and this plan is a secondary plan. If a member or dependent is eligible for Medicare due to end stage renal disease, this plan is primary for the first thirty (30) months. Medicare is primary after the first thirty (30) months.

(6) The claims administrator, with the consent of the employee or the employee's spouse when the claim is for a spouse, or the parent or guardian when the claim is for a minor child, may release or obtain any data which is needed to implement this provision.

(7) When payments should have been paid under this plan but were already paid under some other plan, the claims administrator shall have the right to make payment to such other plan of the amount which would satisfy the intent of this provision. This payment shall discharge the liability under this plan.

(8) When payments made under this plan are in excess of the amount required to satisfy the intent of this provision, the claims administrator shall have the right to recover the excess payment from one (1) or more of the following:

(A) Any person to whom, for whom or with respect to whom these payments were made;

(B) Any insurance company; or

(C) Any other organization.

(9) The claims administrator will pay benefits promptly, or, if applicable, within their contractual time frame obligations after submittal of due proof of loss unless the claims administrator provides the claimant a clear, concise statement of a valid reason for further delay which is in no way connected with, or caused by the existence of this provision nor otherwise caused by the claims administrator.

(10) If one of the other plans involved (as defined in coordination of benefits provision) provides benefits on an excess insurance or excess coverage basis, subsections (3)(C) and (D) of this rule shall not apply to the plan and this policy will pay as excess coverage.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.075 Review and Appeals Procedure

PURPOSE: This rule establishes the policy of the board of trustees in regard to review and appeals procedures for participation in the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 20, 2004, effective January 1, 2005, expires June 29, 2005.*

(1) When any participant shall suffer any injury or sickness giving rise to claim under these rules, s/he shall have free choice of providers practicing legally in the location in which service is provided to the end that a provider/patient relationship shall be maintained. Reimbursement will be in accordance with the benefit provisions of the type of coverage chosen by the participant.

(2) The plan administrator, agent or claims administrator, upon receipt of a notice of request, shall furnish to the employee the forms as are usually furnished for filing proofs of loss. If the forms are not furnished within thirty (30) days after the giving of such notice, the employee shall be deemed to have complied with the requirement as to proof of loss upon submitting, within the time fixed for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which request is made.

(3) Written proof of claims incurred should be furnished to the claims administrator as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the claims administrator before they are paid.

(4) In the case of medical benefits, the claims administrator will send written notice of any amount applied toward the deductible as well as any payments made. The claims administrator may also send a request for additional information or material to support the claim, along with reasons why this information is necessary.

(5) All insured members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the health maintenance organization (HMO), point-of-service (POS), or preferred provider organization (PPO) health plan contract applicable to the insured member. Only after these procedures have been exhausted may the member appeal directly to the Missouri Consolidated Health Care Plan Board of Trustees to review the decision of the health plan contractor.

(A) Appeals to the board of trustees shall be submitted in writing within forty-five (45) days of receiving the final decision from the

member's health care plan, specifically identifying the issue to be resolved and be addressed to:

Attn: Appeal
Board of Trustees
Missouri Consolidated Health Care Plan
PO Box 104355
Jefferson City, MO 65110

(B) The board may utilize a hearing officer, such as the Administrative Hearing Commission, to conduct a fact-finding hearing, and make proposed findings of fact and conclusions of law.

1. The hearing will be scheduled by the MCHCP.

2. The parties to the hearing will be the insured and the applicable health plan.

3. All parties shall be notified in writing of the date, time and location of the hearing.

4. All parties shall have the right to appear at the hearing and submit written or oral evidence. The appealing party shall be responsible for all copy charges incurred by MCHCP in connection with any documentation that must be obtained through the MCHCP. These fees will be reimbursed should the party prevail in his/her appeal. They may cross-examine witnesses. They need not appear and may still offer written evidence. The strict rules of evidence shall not apply.

5. The party appealing to the board shall carry the burden of proof.

6. The independent hearing officer shall propose findings of fact and conclusions of law, along with its recommendation, to the board. Copies of the summary, findings, conclusions and recommendations shall be sent to all parties.

(C) The board may, but is not required to, review the transcript of the hearing. It will review the summary of evidence, the proposed findings of fact and conclusions of law and shall then issue its final decision on the matter.

1. All parties shall be given a written copy of the board's final decision.

2. All parties shall be notified that if they feel aggrieved by the final decision, they shall have the right to seek judicial review of the decision within thirty (30) days of its receipt, as provided in sections 536.100 to 536.140, RSMo.

(D) Administrative decisions made solely by MCHCP may be appealed directly to the board of trustees, by either an insured member or health plan contractor.

1. All the provisions of this rule, where applicable, shall apply to these appeals.

2. The parties to such appeal shall be the appellant and the MCHCP shall be respondent.

3. The appellant, if aggrieved by the final decision of the board, shall have the right of appeal as stated in subsection (5)(C) herein.

4. In reviewing these appeals, the board and/or staff may consider:

A. Newborns—

(I) Notwithstanding any other rule, if a member currently has children coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within six (6) months of the child's date of birth. If a member does not currently have children coverage under the plan but states that the required information was provided within the thirty-one (31)-day enrollment period, he/she must sign an affidavit stating that their information was provided within the required time period. The affidavit must be notarized and received in the MCHCP office within thirty-one (31) days after the date of notification from the MCHCP; and

(II) Once the MCHCP receives the signed affidavit from the member, coverage for the newborn will be backdated to the date of birth, if the request was made within six (6) months of the child's date of birth. The approval notification will include language that the MCHCP has no contractual authority to require the contractors to pay for claims that are denied due to the retroactive effective date. If an enrollment request is made under either of these two (2) scenarios past six (6) months following a child's date of birth, the information will be forwarded to the MCHCP board for a decision.

B. Credible evidence—Notwithstanding any other rule, the MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office or the MCHCP, that was no fault of the member.

C. Change of plans due to dependent change of address—A member may change plans outside the open enrollment period if his/her covered dependents move out of state and their current plan cannot provide coverage.

(E) Any member wishing to appeal their enrollment selection completed during the annual open enrollment period must do so in writing to the board of trustees within thirty (30) calendar days of the beginning of the new plan year. The MCHCP will respond within thirty (30) calendar days of the receipt of the appeal.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

EMERGENCY RULE

22 CSR 10-3.080 Miscellaneous Provisions

PURPOSE: This rule establishes the policy of the board of trustees in regard to miscellaneous provisions under the Missouri Consolidated Health Care Plan.

EMERGENCY STATEMENT: This emergency rule must be in place by January 1, 2005, in accordance with the new plan year. Therefore, this rule is necessary to protect members (employees, retirees and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of having their health insurance coverage interrupted due to confusion regarding eligibility or availability of benefits. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this rule be registered immediately in order to maintain the integrity of the current health care plan. This emergency rule must become effective January 1, 2005, in order that an immediate danger is not imposed on the public welfare. This rule reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. This emergency rule complies with the protections extended by the ***Missouri*** *and* ***United States Constitutions*** *and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. Emergency rule filed December 20, 2004, effective January 1, 2005, expires June 29, 2005.*

(1) Termination of the Plan. Any other provision of this plan to the contrary notwithstanding, no benefit will be paid for charges incurred by a participant or former participant after the termination of this plan.

(2) Facility of Payment. Plan benefits will be paid to the employee if living and capable of giving a valid release for the payment due. If the participant, while living, is physically, mentally or for any other reason incapable of giving a valid release for any payment due, the claims administrator at his/her option, unless and until request is made by the duly appointed guardian, may pay benefits which may become due to any blood relative or relative connected by marriage to the participant, or to any other person or institution appearing to the claims administrator to have assumed responsibility for the affairs of the participant. Any payments made by the claims administrator in good faith pursuant to this provision shall fully discharge the claims administrator to the extent of the payment. Any benefit unpaid at the time of the employee's death will be paid to the employee's estate. If any benefits shall be payable to the estate of the employee, the claims administrator may pay these benefits to any relative by blood or connection by marriage of the employee who is deemed by the claims administrator to be equitably entitled to it. Any payments made by the claims administrator in good faith pursuant to this provision shall fully discharge the claims administrator to the extent of this payment. Subject to any acceptable written direction and assignment by the employee, any benefits provided, at the claims administrator's option, may be paid directly to an eligible provider rendering covered services; but it is not required that the service be rendered by a particular provider.

(3) Confidentiality of Records. The health records of the participants in the plan are confidential and shall not be disclosed to any person, except pursuant to a written request by, or with the prior written consent of, the individual to whom the records pertain, unless disclosure of the records would be to the officers and employees of the plan or claims administrator or his/her legal representatives who have a need for the records in the performance of their duties; or unless disclosure would be for a routine use by the plan or claims administrator for a purpose which is compatible with the purpose for which it was collected; or unless disclosure of the records would be to the commissioner of administration, or his/her legal representative, for the sole purpose of preventing fraudulent or redundant medical claims to either the Missouri Consolidated Health Care Plan, Missouri, or other public entities as an employer or self-insurer of Workers' Compensation for use in the investigation of a Workers' Compensation claim; or unless disclosure of the records is to the participant to whom the record pertains; or unless disclosure of the record is pursuant to the order of a court of competent jurisdiction. The parent of any minor, or the legal guardian of any individual who has been declared to be incompetent due to physical or mental incapacity by a court of competent jurisdiction, may act on behalf of the individual.

(4) Should any provision of this plan conflict with the requirements of federal or state law, including but not limited to the Health Insurance Portability and Accountability Act, Family and Medical Leave Act, the Americans with Disabilities Act or the Older Workers Benefit Protection Act, the plan shall be administered in such a way as to comply with the requirements of law, and will be deemed amended to conform with law.

(5) This document will be kept on file at the principal offices of the plan administrator and may be inspected by a participant during regular business hours. Also, the plan administrator reserves the right at any time to modify or amend, in whole or in part, any or all provisions of the plan.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo Supp. 2003.

EXECUTIVE ORDER
05-01

The Executive Order denoted 01-09 is hereby rescinded.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 11th day of January, 2005.

Matt Blunt
Governor

ATTEST:

Robin Carnahan
Secretary of State

EXECUTIVE ORDER
05-02

WHEREAS, it is vital to the economic health and prosperity of Missouri that State government be conducted in the most business-like and economical manner, and that the people of this State be assured that their tax dollars be spent wisely; and

WHEREAS, immediate cost containment will assist in reducing State expenditures and improving the condition of the general revenue fund and other revenue funds; and

WHEREAS, one way to obtain immediate cost containment is to freeze the leasing or purchasing of non-emergency motor vehicles, cellular phones, and new office space, for all State agencies and departments in the Executive Branch of State government;

NOW THEREFORE, I, Matt Blunt, Governor of the State of Missouri, by virtue of the authority vested in me by the Constitution and laws of the State of Missouri, do hereby order as follows:

(1) All State agencies and departments in the Executive Branch shall not enter into any agreement or contract to lease or purchase any non-emergency motor vehicles, except as may be determined by the Commissioner of Administration to be in the best interest of the State.

(2) All State agencies and departments in the Executive Branch shall not enter into any agreement or contract to lease or purchase any cellular phones, except as may be determined by the Commissioner of Administration to be in the best interest of the State.

(3) All State agencies and departments in the Executive Branch shall not enter into any agreement or contract to lease or purchase new office space, except as may be determined by the Commissioner of Administration to be in the best interest of the State.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 11th day of January, 2005.

Matt Blunt
Governor

ATTEST:

Robin Carnahan
Secretary of State

EXECUTIVE ORDER
05-03

WHEREAS, the State of Missouri currently maintains an office in Washington, D.C.; and

WHEREAS, the stated purpose of the Washington, D.C. office has been to represent the State's interests in Washington and to monitor Federal legislation; and

WHEREAS, the annual cost to Missouri of maintaining the Washington, D.C. office is more than $164,000; and

WHEREAS, it is vital to Missouri that State government be conducted in the most business-like and economical manner, and that the people of this State be assured that their tax dollars are spent wisely; and

WHEREAS, the continued operation of the Washington, D.C. office is not vital to the State's interests; and

WHEREAS, the State of Missouri has nine members of the United States House of Representatives and two members of the United States Senate making up a delegation capable of safeguarding the State's interests; and

WHEREAS, the State of Missouri will realize immediate savings upon the closing of the Washington, D.C. office by eliminating duplication of activities and administrative costs.

NOW THEREFORE, I, Matt Blunt, Governor of the State of Missouri, by virtue of the authority vested in me by the Constitution and laws of the State of Missouri, do hereby order the Commissioner of Administration to take whatever steps are necessary to close the Washington, D.C. office as soon as possible.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 11th day of January, 2005.

Matt Blunt
Governor

ATTEST:

Robin Carnahan
Secretary of State

EXECUTIVE ORDER
05-04

WHEREAS, emergencies may arise at any time, including but not limited to power outage due to tornado, rain, snow or ice storm, propane or gas shortages due to extremely cold conditions requiring carriers to travel out of state to haul fuel and distribute such fuel upon their return, flooding conditions, potential terrorist attack, or other unforeseen emergencies; and

WHEREAS, many of these emergencies occur after normal working hours or on holidays; and

WHEREAS, the safety and welfare of the inhabitants of the affected area may require the rapid identification of an emergency situation that necessitates the need to suspend federal commercial driver laws; and

WHEREAS, Section 390.23 of Title 49, Code of Federal Regulations, provides that a Governor of a State, or the Governor's authorized representatives having authority to declare emergencies, may declare an emergency thereby exempting motor carriers or drivers operating a commercial vehicle from the Federal Motor Carrier Safety Regulations, including the drivers' hours of service regulations in Part 395 of Title 49, Code of Federal Regulations, both while providing assistance to the emergency relief efforts during the emergency, and while returning empty to the motor carrier's terminal or driver's normal work reporting location.

NOW THEREFORE, I, Matt Blunt, Governor of the State of Missouri, by virtue of the authority vested in me by the Constitution and laws of the State of Missouri, do hereby order as follows:

(1) The Director of the Missouri Department of Transportation is authorized to issue an emergency declaration of a regional emergency within the meaning of 49 CFR section 390.23(a)(1) or a local emergency within the meaning of 49 CFR section 390.23(a)(2) for the limited purpose of temporarily suspending the usual requirements of Part 395 of Title 49, Code of Federal Regulations, with reference to motor carriers and operators of commercial motor vehicles, when such official determines that an emergency situation exists which requires the suspension of federal commercial driver laws. An emergency declaration issued pursuant to this order shall not exceed the duration of the motor carrier's or driver's direct assistance in providing emergency relief, or five days from the date of the initial declaration of the emergency, whichever is less.

(2) The Director of the Missouri Department of Transportation shall notify the Governor's office as soon as possible of any emergency declarations issued pursuant to this order.

This order shall terminate on January 11, 2006, unless extended or revoked in whole or in part.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 11th day of January, 2005.

Matt Blunt
Governor

ATTEST:

Robin Carnahan
Secretary of State

Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of the proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register.* If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety (90)-day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:
Boldface text indicates new matter.
[Bracketed text indicates matter being deleted.]

Title 4—DEPARTMENT OF ECONOMIC DEVELOPMENT
Division 250—Missouri Real Estate Commission
Chapter 5—Fees

PROPOSED AMENDMENT

4 CSR 250-5.030 Miscellaneous Fees. The commission is amending sections (1) and (2).

PURPOSE: This amendment deletes fees pursuant to section 610.026, RSMo which provides fees for copying records related to document search and duplication and establishes a name search fee with the Highway Patrol.

(1) The following miscellaneous fees for certain services rendered by the Missouri Real Estate Commission are as follows:

[(A) Photocopy Fee—public records (per page) $ 0.25;
(B) Document Search Fee—public records
(per hour) $20.00;
with a minimum fee of $ 5.00;
and
(C) Access Fee—public records maintained on computer facilities, recording tapes or discs, video tapes or films, pictures, slides, graphics, illustrations or similar audio or visual items or devices actual cost of reproduction plus document search fee of
(per hour) $20.00;
with a minimum fee of $ 5.00.]

(A) Name Search Fee
(as determined by the Missouri State Highway Patrol)

(2) Payment of any copying fees and search fees **pursuant to section 610.026, RSMo** may be required before any information will be provided.

*AUTHORITY: sections 339.120, RSMo [Supp. 1993] **2000** and 610.026, [RSMo Supp. 1987] **as amended by SB 1020 (2004) and section 43.543, RSMo Supp. 2003**. Original rule filed March 16, 1988, effective July 1, 1988. Amended: Filed Feb. 2, 1994, effective Aug. 28, 1994. Amended: Filed Dec. 30, 2004.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will cost private entities an estimated thirty thousand dollars ($30,000) annually for the life of the rule. It is anticipated that the total cost will recur annually for the life of the rule, may vary with inflation and is expected to increase annually at the rate projected by the Legislative Oversight Committee.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Real Estate Commission, Janet Carder, Executive Director, PO Box 1339, Jefferson City, MO 65102, by facsimile at (573) 751-2777, or via e-mail at realestate@pr.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

PRIVATE ENTITY FISCAL NOTE

I. RULE NUMBER

Title 4 -Department of Economic Development

Division 250—Missouri Real Estate Commission

Chapter 5—Fees

Proposed Amendment - 4 CSR 250-5.030 Miscellaneous Fees

Prepared October 6, 2004 by the Division of Professional Registration

II. SUMMARY OF FISCAL IMPACT

Estimate the number of entities by class which would likely be affected by the adoption of the proposed amendment:	Classification by type of the business entities which would likely be affected:	Estimated biennial cost of compliance with the amendment by affected entities:
6,000	Applicants (Name Search Fee - $5)	$30,000
	Estimated Annual Cost of Compliance for the Life of the Rule	**$30,000**

III. WORKSHEET

See table above.

IV. ASSUMPTION

1. The figures reported above are based on FY04 actuals and FY05 projections.
2. The Missouri Highway Patrol establishes the name search fee, therefore, applicants may incur a variance in cost should those fees be increased or decreased.
3. It is anticipated that the total cost will recur annually for the life of the rule, may vary with inflation and is expected to increase annually at the rate projected by the Legislative Oversight Committee.

Title 9—DEPARTMENT OF MENTAL HEALTH
Division 10—Director, Department of Mental Health
Chapter 5—General Program Procedures

PROPOSED RULE

9 CSR 10-5.205 Report of Unusual Events

PURPOSE: This rule prescribes procedures for documenting, reporting, analyzing and addressing events including medication errors and incidents that affect individuals in residential facilities, day programs or specialized services that are licensed, certified or funded by the Department of Mental Health as required by sections 630.005, 630.020, 630.165 and 630.655, RSMo.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) The following words and terms, as used in this rule, mean:

(A) Catastrophic event, any event that occurs with a consumer or facility that would result in possible media attention to either the provider or the department;

(B) Consumer, individual receiving department funded or contracted services, including case management only services, directly from any program or facility;

(C) Corrective action plan, the document a provider submits to the department in response to the results of an event or events which outlines those measures that are intended to reduce the likelihood that the event(s) will recur or to remediate a deficiency. Such actions include but are not limited to: removal of an individual receiving services or staff from a provider; staff training; improvements in the physical plant; revision of operating procedures; contractual sanctions; suspension or revocation of a license/certificate;

(D) Department, the Department of Mental Health's local regional center, district administrator, or supported community living office, depending on the division providing service;

(E) Guardian, individual who is legally responsible for the care and custody of the consumer;

(F) Incident, an event that was an unusual occurrence or led to an undesirable outcome. This includes but is not limited to injury, death, suspicion or allegation of abuse/neglect/misuse of funds-property, elopement or other incident types identified on the department's Report Form;

(G) "On Call" system, procedure of the specific regional department personnel being available to receive notification of events during non-business hours. A telephone number is provided to verbally relay this information to the individual representing the specific region and division providing service;

(H) Provider, a residential facility, day program or specialized service that is licensed, certified or funded by the Department of Mental Health. Duties of the provider under this rule are the responsibility of the chief administrative officer of the residential facility, day program or specialized service, or his/her designee;

(I) Report Form, Department of Mental Health form for reporting unusual events to the department. The form is used for data entry into the department Incident and Investigation Tracking System for statewide data collection. This form is identified as DMH-9719 which is incorporated by reference and available to the public from the Department of Mental Health, PO Box 687, Jefferson City, MO 65102. This rule does not include any later amendment or additions; and

(J) Systemic issues—a pattern of events, allegations or practices which are indicative of an operational deficiency within a provider including, but not limited to, licensing, certification, contractual agreements, rights violations, policies, management and/or training.

(2) This section applies to event notification and reporting requirements for employees of providers, as defined under section 630.005, RSMo.

(A) Providers must maintain written policies requiring their employees to report events under this regulation and those events identified in 9 CSR 10-5.200. The policies must make clear that administrative or disciplinary sanctions may result from failure to report. Providers must ensure that their employees and those who support the agency are educated about the department's notification and reporting requirements.

(B) It is the responsibility of the provider to—

1. Notify the department with a written or verbal report of all events reportable under this regulation as identified on the Report Form or guidelines. All events are to be reported immediately, unless otherwise specified on the Report Form or guidelines. If a verbal report, it will be followed up in writing on the Report Form and faxed or otherwise transmitted to arrive within one (1) business day to the appropriate department office;

2. Notify the department using the department's "On Call" system for catastrophic events and other reportable events requiring immediate department notification that occur after 5:00 p.m. or on weekends/holidays; and

3. Verbally notify the legal guardian or parent (if consumer is a minor) of event/incident types (requiring immediate notification to the department) on the Report Form within twenty-four (24) hours of knowledge of an event and that the event has been reported to the department, unless there are event/incident types specifically not requiring notification as specified on the Report Form. The only exception to this is if the parent(s) or legal guardian is the suspected primary person involved that forms the basis for the reported event. If the provider is unable to verbally contact the guardian/parent, the provider shall document on the Report Form all efforts made to comply.

(3) The provider shall develop and implement written procedures for the internal review of reportable events. The provider shall review and analyze reportable events to identify patterns and trends to prevent the reoccurrence of such events and to identify systemic issues, on an annual basis. Upon request by the department, the provider shall provide evidence that this review has been conducted and that appropriate action has been taken.

(4) The provider shall ensure that patterns and trends of reportable events, specific to a consumer, are included and addressed in the consumer's personal/treatment plan upon approval by the planning team. To the extent that specific consumer and systemic issues are identified, the department staff may meet with the provider to discuss action steps to address and resolve issues, including submission of corrective action plans.

(5) The department may request a corrective action plan be provided by the provider based on the facts surrounding the event. This plan is subject to approval of the department within a time frame specified by the department. This plan must be carried out as specified.

(6) Programs licensed or certified by the department must maintain internal records of incidents involving individuals receiving no department funded or contracted services, to include appropriate quality assurance and follow-up of these incidents. These records must be available for review by the department as needed for monitoring or licensure/certification activities.

(7) Failure to follow the above referenced regulations may result in administrative sanctions up to and including contract cancellation or licensure/certification revocation.

AUTHORITY: sections 630.005, 630.020 and 630.655, RSMo 2000 and 630.165, RSMo Supp. 2003. Original rule filed Dec. 20, 2004.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule by writing to Scott Giovanetti, Investigations Program Director, Department of Mental Health, PO Box 687, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 35—Children's Division
Chapter 30—Voluntary Placement Agreement

PROPOSED RULE

13 CSR 35-30.010 Voluntary Placement Agreement Solely for the Purpose of Accessing Mental Health Services and Treatment for Children Under Age Eighteen (18)

PURPOSE: This rule sets forth procedures to be followed to divert children from Children's Division (CD) legal custody when a parent is unable to access or afford clinically indicated mental health services for their child and the child otherwise is not the subject of parental abuse, neglect or abandonment.

(1) Parents or legal guardians (parents) who are considering relinquishing custody solely for the purpose of accessing clinically indicated mental health services for their child or who otherwise cannot afford such services shall be referred by the Children's Division (CD) or Juvenile Court to the Department of Mental Health (DMH) or their designee for an assessment of eligibility to enter into a Voluntary Placement Agreement (VPA) in accordance with Chapter 536, RSMo.

(2) The Department of Social Services-Children's Division (DSS-CD) and the DMH shall develop protocol, policy and procedure to assess the level and extent of services needed for such children and to develop criteria for determining whether a child may be appropriate for a VPA in accordance with Chapter 536, RSMo.

(3) If DMH determines pursuant to the procedures, policies, and protocols as indicated in section (2) above, that the child requires services that cannot be provided in the home and the parent is currently unable to access or financially afford the clinically indicated care the child requires, the parent may enter into a VPA with the DSS-CD.

(A) A VPA means a written agreement between the DSS-CD and a parent, legal guardian, or custodian of a child under age eighteen (18) in need of out-of-home placement, solely because he/she is in need of mental health treatment and services.

(B) A VPA developed following a DMH assessment and certification of appropriateness authorizes the DSS-CD to administer the placement and care of a child while the parent, legal guardian, or custodian of the child retains legal custody.

(4) The DSS-CD will authorize the DMH to place the child, administer the placement, and provide care and treatment for the child while he/she is under the Voluntary Placement Agreement.

(5) The DMH shall ensure that a child's placement, under the VPA, shall be in the most appropriate and least restrictive environment available for the shortest period of time as clinically indicated.

(6) The VPA shall be effective the date the child is placed. Voluntary Placement Agreements may be for as short a period as the parties may agree in the best interests of the child but under no circumstances shall the total period of time that a child shall remain in care under a VPA exceed one hundred eighty (180) days. Subsequent agreements may be entered into, but the total period of placement of the child under a single VPA or a series of VPAs shall not exceed one hundred eighty (180) days without the express authorization of the director of the Children's Division or his/her designee.

(7) The parents, DMH and DSS-CD shall hold a family support team meeting to develop a permanency/treatment plan for the child either prior to or within seventy-two (72) hours of the date of placement of the child pursuant to a VPA. The permanency/treatment plan shall be completed and in place no later than sixty (60) days from the date that the child is placed according to the agreement.

(8) The parents, the DSS-CD and DMH shall hold a family support team meeting no later than one hundred (100) days from the date that the child is placed pursuant to a VPA to determine whether:

(A) The parties have exercised reasonable efforts to finalize the permanency plan; and

(B) Whether it is in the best interests of the child to either terminate the VPA and reunite the child with the child's parents or whether it is in the best interests of the child to continue the child in care beyond the expiration date of the VPA.

(9) The DSS-CD shall maintain responsibility for compliance with all Federal Title IV-E requirements. All Voluntary Placement Agreements shall be consistent with the requirements of sections 210.108 and 210.710, RSMo and Title IV-E of the Social Security Act and its implementing regulations, including, but not limited to 42 U.S.C. section 672.

(10) DMH shall develop and submit to DSS-CD at prescribed intervals a report of services provided to any child served under a VPA. Such report shall include any information identified by DSS-CD as required for federal reporting purposes.

(11) The VPA may be terminated by the DSS-CD upon ten (10) days written notice to the parties.

(12) The parent(s) may terminate the VPA for any reason at any time by providing either oral or written notification to DSS-CD. Upon receipt of such notice the VPA shall immediately terminate and the child shall be returned to the legal and physical custody of the parents.

(13) All VPAs shall be in writing and shall be on a form approved by the DSS-CD in consultation with the DMH.

AUTHORITY: section 210.108, RSMo Supp. 2004. Emergency rule filed Dec. 23, 2004, effective Jan. 2, 2005, expires June 30, 2005. Original rule filed Dec. 23, 2004.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Children's Division, Frederic M. Simmens, Director, PO Box 88, Jefferson City, MO 65103. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 35—Children's Division
Chapter 50—Licensing

PROPOSED RULE

13 CSR 35-50.010 Accreditation as Evidence for Meeting Licensing Requirements

PURPOSE: This rule establishes the procedures to be followed in order for an organization to qualify for a license under sections 210.481 through 210.511, RSMo by the agency being accredited by Council on Accreditation of Services for Children and Families, Inc., the Joint Commission on Accreditation of Healthcare Organizations, or the Commission on Accreditation of Rehabilitation Facilities (accreditation bodies).

(1) The Children's Division shall accept accreditation by Council on Accreditation of Services for Children and Families, Inc., the Joint Commission on Accreditation of Healthcare Organizations, or the Commission on Accreditation of Rehabilitation Facilities, as specified in section (2) of this rule, as *prima facie* evidence that the organization meets licensing requirements under sections 210.481 through 210.511, RSMo.

(2) Type of License.

(A) The organization shall provide to the Children's Division, sufficient evidence that they are accredited in the service or program for which they are requesting a license.

(B) If a service or program, including but not limited to child placing, maternity, infant/toddler, residential treatment, and intensive residential treatment in residential child care, is not accredited by the accrediting body, than the organization must apply for and meet all other licensing requirements as put forth by the division.

(3) Application/Reapplication for License for Accredited Organizations:

(A) The organization shall present to the division—

1. A copy of the organization's official final accreditation report and accreditation certificate; and

2. A list of operating sites which includes the capacity served, the gender served, and the ages served by that organization. This list must be updated if there is a change in operating sites by the organization;

(B) If the organization has not been previously licensed by the state of Missouri, an on-site visit may be required by the division before a license is issued;

(C) The division shall examine the areas that the organization is applying for a license. The division then shall issue a corresponding license for those areas in which the organization is accredited. The license shall be valid for the period of time up to two (2) years, or when the organization's accreditation expires, whichever is shorter;

(D) Nothing in this section will result in the loss of license if the accreditation certificate has expired, but the organization is still in good standing and the re-accreditation process is being pursued. The division may, at its discretion, request a letter of good standing from the accrediting body; and

(E) Any denial or revocation of license based upon an organization's accreditation standing is entitled to a hearing as specified under the licensing rules or they may undergo the licensing process and meet all licensing rules in order to obtain a license.

(4) Information Sharing.

(A) The organization shall notify the division immediately of any sentinel event and of any revocation of accreditation.

(B) Sentinel events are as defined by the accrediting body, but shall at a minimum include the following:

1. A death of a child in one of the organization's facilities; or

2. A serious injury of a child in one of the organization's facilities; or

3. A fire in a location routinely occupied by children, which requires the fire department to be called; or

4. An allegation of child abuse, physical or sexual, or neglect which is substantiated by the division or through an internal investigation by the organization which occurs within a facility; or

5. An employee is terminated from employment in relation to the safety and care of children; or

6. There is any change in the chief executive officer; or

7. There is a lawsuit filed against the organization by or on behalf of a person who is or was in the organization's care; or

8. Any known criminal charges are filed against the facility, organization, any resident of the facility, or any employee or volunteer who has contact with children.

(C) The organization shall notify the division of the entrance, exit and any performance review meetings of the accrediting body which are held in conjunction with the accreditation of the organization. The division has a right to attend any or all of these meetings between the organization and the accrediting body.

(5) The division may make such inspections and investigations as it deems necessary to conduct an initial visit to a facility not previously licensed, for investigative purposes involving complaints of alleged child abuse or neglect, at reasonable hours to address a complaint concerning the health and safety of children which the organization serves, or any other mutually agreed upon time.

AUTHORITY: section 210.112, RSMo Supp. 2004. Emergency rule filed Dec. 23, 2004, effective Jan. 2, 2005, expires June 30, 2005. Original rule filed Dec. 23, 2004.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Children's Division, Frederic M. Simmens, Director, PO Box 88, Jefferson City, MO 65103. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 10—Nursing Home Program

PROPOSED AMENDMENT

13 CSR 70-10.110 Nursing Facility Reimbursement Allowance. The division is amending sections (1) and (2) and adding section (3).

PURPOSE: This amendment clarifies the NFRA regulation, updates the applicable quarterly survey to be used in determining the NFRA assessment and provides for an adjustment to the NFRA for qualifying facilities.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Nursing Facility Reimbursement Allowance (NFRA). NFRA shall be assessed as described in this section.

(A) Definitions.

1. Nursing facility. An institution or a distinct part of an institution which—

A. Is primarily engaged in providing to residents—

(I) Skilled nursing care and related services for residents who require medical or nursing care; or

(II) Rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

(III) On a regular basis, health-care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases; and

B. Has in effect a transfer agreement with one (1) or more hospitals as required by federal law; and

C. Meets the requirements for a nursing facility described in section 1919(b)–(d) of the Social Security Act; or

D. Is licensed in accordance with Chapter 198, RSMo as a skilled nursing facility.

2. Fiscal period. A facility's twelve (12)-month fiscal reporting period covering the same twelve (12)-month period as its federal tax year.

3. Department. Department of Social Services.

4. Director. Director of the Department of Social Services.

5. Division. Division of Medical Services, Department of Social Services.

6. *[Division of Aging]* **Department of Health and Senior Services (DHSS)**. The *[division of the Department of Social Services]* **Missouri state agency** responsible for *[surveys, certification and licensure of nursing facilities]* **licensing and inspecting all long-term care facilities operating in Missouri and certifying annually those facilities participating in the Medicare or Medicaid program**.

7. Engaging in the business of providing nursing facility services. Accepting payment for nursing facility services rendered.

8. Quarterly survey. The survey filled out each quarter by a nursing facility providing data on its licensed and certified beds and the related resident occupancy days (ROD) that is submitted to the DHSS. The survey form, "Missouri Department of Health and Senior Services, Division of Senior Services and Regulation, ICF/SNF Certificate of Need Quarterly Survey" (form MO 886-9001 (6-95)), incorporated by reference in this rule, is published by the Department of Health and Senior Services, Division of Senior Services and Regulation, PO Box 570, Jefferson City, MO 65102. This rule does not incorporate any subsequent amendments or additions.

9. Applicable quarterly survey. The quarterly survey used by the division from which the patient occupancy days are taken to determine the NFRA assessment for a given period as set forth in section (2).

*[8.]***10.** Patient occupancy days. The number of days **that residents occupied the licensed beds in a nursing facility** as shown on the *[Division of Aging's]* quarter**ly** survey**, line D**. **"Number of occupied RODs (days patients in beds or beds held)."**

*[9.]***11.** *[Total]* **Annualized level of** patient occupancy days. **The annual level of patient occupancy days used to determine the annual NFRA assessment.**

A. For existing nursing facilities whose NFRA assessment is set in accordance with (1)(B)1. of this regulation, the annualized level of patient occupancy days is calculated by taking *[T]***/**the number of patient occupancy days shown on **line D. of** the *[Division of Aging's]* quarter**ly** survey multiplied by four (4).

B. For nursing facilities whose NFRA assessment is not set by the general rule set forth in (1)(B)1. (i.e., it is an exception set under (1)(B)1.A., is a new facility set under (1)(B)2., qualifies for a NFRA Adjustment in accordance with section (3), etc.), the annualized level of patient occupancy days may be calculated differently and is set forth in those sections.

*[10.]***12.** Licensed beds. Any skilled nursing facility or intermediate care facility bed meeting the licensing requirement of the *[Division of Aging or the]* Missouri Department of Health **and Senior Services**.

13. Licensed bed days. The total number of patient days available for use during a given period for all licensed beds. For purposes of this regulation, licensed bed days are calculated for an annual period and is the number of licensed beds times three hundred sixty-five (365) days.

14. Change of ownership. A change in the ownership, control, operator or leasehold interest.

(B) Each nursing facility, except any nursing facility operated by the Department of Mental Health, engaging in the business of providing nursing facility services in Missouri shall pay a Nursing Facility Reimbursement Allowance (NFRA).

1. The NFRA owed for existing nursing facilities shall be calculated by multiplying the NFRA rate by the annualized level of patient occupancy days from the applicable *[Division of Aging ICF/SNF Certificate of Need]* Quarterly Survey. The NFRA shall be divided by and collected over the number of months for which each NFRA rate is effective. The NFRA rates, effective dates and applicable quarterly surveys are set forth in section (2).

A. Exceptions.

(I) If an existing nursing facility's applicable quarterly survey, as set forth in section (2), does not represent a full quarter's worth of days due to a termination, temporary closure, change of ownership, etc., the **annualized level of** patient occupancy days used to determine the NFRA shall be the greater of:

(a) The **annualized level of patient occupancy days from the** quarterly survey immediately prior to the applicable quarterly survey, if it represents a full quarter's worth of days; or

(b) Fifty percent (50%) of licensed bed*/s/* **days (i.e., number of licensed beds times three hundred sixty-five (365) days times fifty percent (50%))**.

(II) If an existing nursing facility did not have patient occupancy information included on the applicable quarterly survey due to a termination, temporary closure, change of ownership, etc., the **annualized level of** patient occupancy days used to determine the NFRA shall be the greater of:

(a) The **annualized level of patient occupancy days from the** quarterly survey immediately prior to the applicable quarterly survey, if it represents a full quarter's worth of days; or

(b) Fifty percent (50%) of licensed bed*/s/* **days**.

(III) If a nursing facility has ICF licensed beds and SNF licensed beds and none of the beds are Medicaid certified, only the SNF beds are subject to NFRA. The **annualized level of** patient occupancy days used to determine the NFRA shall be determined by multiplying the occupancy percentage from the applicable quarterly survey by the *[annualized level of patient occupancy]* **licensed bed** days *[based on]* **for** the SNF licensed beds **(i.e., number of SNF licensed beds times three hundred sixty-five (365) days)**.

(IV) If two (2) existing nursing facilities merge, with one (1) nursing facility terminating and transferring its beds to the remaining facility, the NFRA for the two (2) previously independent nursing facilities shall be added together and assessed to the remaining facility.

2. The initial NFRA owed by a newly licensed nursing facility that just opened as a result of receiving a Certificate of Need (CON) for a new nursing facility shall be calculated by multiplying the NFRA rate by the annualized level of patient occupancy days based on fifty percent (50%) of licensed bed*/s/* **days**. The NFRA shall be prorated for the number of months remaining in the NFRA period. If a nursing facility's licensure date is after the first day of a month, the NFRA will be collected beginning with the first day of the month following the actual licensure date.

3. If a nursing facility ceases to provide nursing facility services, the nursing facility is not required to pay the NFRA during the months in which it does not have residents, even though it may retain a license due to temporary closure for renovations, replacement, etc. **If a nursing facility provided nursing facility services for any portion of a month, it shall pay the NFRA for the entire month (i.e., the NFRA shall not be prorated for the month in which it ceases to provide nursing facility services).** If the facility reopens, it shall resume paying the NFRA. It shall owe the same NFRA as it did prior to closing, if the NFRA has not changed per section (2) below. If the NFRA has changed, the facility shall be assessed in accordance with paragraph (1)(B)1. above.

(F) Each nursing facility, upon receiving written notice of the final determination of its Nursing Facility Reimbursement Allowance may file a protest with the director of the department setting forth the grounds on which the protest is based, within thirty (30) days from the date of receipt of written notice from the department. The director of the department shall reconsider the determination and, if the nursing facility so requested, the director or the director's designee shall grant the nursing facility a hearing to be held within forty-five (45) days after the protest is filed, unless extended by agreement between the nursing facility and the director. The director shall issue a final decision within forty-five (45) days of the completion of the hearing. After a final decision by the director, a nursing facility's appeal of the director's final decision shall be to the Administrative Hearing Commission in accordance with sections 208.156, RSMo and 621.055, RSMo.

(2) NFRA Rates. The NFRA rates determined by the division, as set forth in (1)(B) above, are as follows:

(H) The NFRA will be seven dollars and thirty cents ($7.30) per patient occupancy day, effective July 1, 2001. The applicable quarterly survey for this period shall be the Division of Aging's December 2000 quarterly survey**;** *[and]*

(I) The NFRA will be eight dollars and forty-two cents ($8.42) per patient occupancy day, effective July 1, 2003. The applicable quarterly survey for this period shall be the Department of Health and Senior Services' December 2002 quarterly survey*[.]***;**

(J) Effective January 1, 2005, the applicable quarterly survey shall be the June 2004 quarterly survey. The NFRA will continue to be eight dollars and forty-two cents ($8.42) per patient occupancy day; and

(K) Effective July 1, 2005, the applicable quarterly survey shall be updated at the beginning of each state fiscal year using the previous December's quarterly survey.

(3) NFRA Adjustment Request. A facility being assessed the NFRA may request that its current NFRA assessment be adjusted, as set forth below.

(A) Qualifying Criteria. In order for a facility to receive an adjustment to its current NFRA assessment, it must meet all of the following criteria:

1. The facility must decrease its licensed bed capacity by at least fifteen percent (15%).

2. The facility must draft a written statement documenting that the decrease in licensed bed capacity is intended to be permanent.

A. If the facility increases its licensed capacity back to the original capacity within one (1) year of the decrease, the NFRA Adjustment shall be voided and the facility shall resume paying the original NFRA beginning with the first of the month in which the facility made the request to DHSS to increase licensed capacity.

3. The annualized level of patient occupancy days currently being assessed is not possible to attain because it is greater than one hundred percent (100%) of its new licensed capacity. For example, assume a facility had one hundred thirty (130) licensed beds and was being assessed on an average of one hundred (100) beds:

A. If a facility decreased its license by twenty (20) beds, being left with a total of one hundred ten (110) licensed beds, the facility could still obtain the occupancy at which it was assessed (i.e., one hundred (100) beds being assessed is less than the one hundred ten (110) licensed bed capacity). Therefore, it would not meet the criteria for a NFRA Adjustment.

B. If a facility decreased its license by forty (40) beds, being left with a total of ninety (90) licensed beds, the facility could not obtain the occupancy at which it was assessed (i.e., one hundred (100) beds being assessed is greater than the ninety (90) licensed bed capacity). Therefore, it would meet the criteria for a NFRA Adjustment.

4. The facility must submit a written request to the Division that includes an explanation as to why it believes it qualifies for an adjustment to its NFRA and documentation supporting its request. The following documentation is required:

A. A copy of the facility's request submitted to the DHSS and/or the CON program that its licensed bed capacity be decreased.

B. A copy of the license issued as a result of the request for the decrease and all licenses issued from that point forward to the current license.

C. If the facility's request submitted to the DHSS and/or the CON program to decrease its licensed bed capacity did not include a statement that the facility intended for the decrease to be permanent, such a statement must be submitted with the NFRA Adjustment Request.

D. The division may obtain this documentation and any other documentation it deems relevant to satisfy itself that the facility's licensed bed capacity has been decreased and the facility intends for the decrease to be permanent from the facility, the DHSS, the CON program, or any other source it deems appropriate.

E. If the division makes a written request for additional information and the facility does not comply within ninety (90) days of the request, the division shall consider the NFRA Adjustment Request withdrawn.

(B) Calculation of Adjustment. A nursing facility meeting the criteria for a NFRA Adjustment shall have its NFRA recalculated and it shall replace the current NFRA. The revised, adjusted NFRA shall be calculated as follows:

1. The facility's new, decreased licensed bed capacity shall be multiplied by three hundred sixty-five (365) days to determine the annualized level of patient occupancy days.

2. The new annualized level of patient occupancy days shall be multiplied by the current NFRA rate set forth in section (2) to determine the revised annual assessment.

3. The revised annual assessment shall be divided by twelve (12) months to determine the revised monthly assessment that the facility will owe beginning with the effective date of the adjustment.

(C) Effective Date of NFRA Adjustment. The effective date of the NFRA Adjustment shall be the first day of the month following the date the request is received; it will not be retroactive back to the effective date of the original NFRA.

AUTHORITY: sections 198.401, 198.403, 198.406, 198.409, 198.412, 198.416, 198.418, 198.421, 198.424, 198.427, 198.431, 198.433, 198.436 and 208.201, RSMo 2000 and 198.439, RSMo Supp. 2003. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 21, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 15, 1994, effective July 30, 1995. For intervening history please consult the ***Code of State Regulations****. Emergency amendment filed Dec. 17, 2004, effective Jan. 1, 2005, expires June 29, 2005. Amended: Filed Dec. 17, 2004.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be received within thirty (30) days after publication in the ***Missouri Register****. If to be hand-delivered, comments must be brought to the Division of Medical Services at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RESCISSION

22 CSR 10-2.010 Definitions. This rule established the policy of the board of trustees regarding the key terms within the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded due to the filing of a new emergency and proposed rule.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Rescinded: Filed Dec. 20, 2004.*

PUBLIC COST: The fiscal impact of this proposed rescission is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson CIty, Mo 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RULE

22 CSR 10-2.010 Definitions

PURPOSE: This rule establishes the policy of the board of trustees regarding the key terms within the Missouri Consolidated Health Care Plan relative to state members.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) When used in this chapter's rules or the state plan document, these words and phrases have the meaning—

(A) Accident—An unexpected happening resulting in an injury which is not due to any fault or misconduct on the part of the person injured;

(B) Actively at work—You are considered actively at work when performing in the customary manner all of the regular duties of your occupation with the employer either at one (1) of the employer's regular places of business or at some location which the employer's business requires you to travel to perform your regular duties or other duties assigned by your employer. You are also considered to be actively at work on each day of a regular paid vacation or nonworking day on which you are not totally disabled, but only if you are performing in the customary manner all of the regular duties of your occupation with the employer on the immediately preceding regularly scheduled workday;

(C) Administrative guidelines—The interpretation of the plan document as approved by the plan administrator, developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered;

(D) Automatic reinstatement maximum—The maximum annual amount that can be reinstated to an individual's lifetime benefit;

(E) Benefit year—The twelve (12)-month period beginning January 1 and ending December 31;

(F) Benefits—Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator;

(G) Care Support Program—A voluntary program that helps manage a chronic condition with outpatient treatment;

(H) Claims administrator—An organization or group responsible for the processing of claims and associated services for the plan's self-insured benefit programs and preferred provider organization (PPO);

(I) Co-pay plan—A set of benefits similar to a health maintenance organization option;

(J) Cosmetic surgery—A procedure performed primarily to preserve or improve appearance rather than restore the anatomy and/or function of the body which are lost or impaired due to illness or injury;

(K) Covered benefits—A schedule of covered services and charges, including chiropractic services, which are payable under the plan;

(L) Custodial care—Care designed essentially to assist an individual to meet the activities of daily living; for example, assistance in bathing, supervision of medication which can usually be self-administered and which does not entail or require the continuing attention of trained medical or paramedical personnel;

(M) Dependent-only participation—Participation of certain survivors of employees. Dependent participation may be further defined

to include the deceased employee's: 1) spouse only; 2) child(ren) only; or 3) spouse and child(ren);

(N) Dependents—The lawful spouse of the employee, the employee's unemancipated child(ren) and certain survivors of employees, as provided in the plan document and these rules, for whom application has been made and has been accepted for participation in the plan;

(O) Eligibility date—Refer to 22 CSR 10-2.020 for effective date provisions.

1. Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of employment or reemployment.

2. Employees transferred from a state department with coverage under another medical care plan into a state department covered by this plan and their eligible dependents who were covered by the other medical care plan will be eligible for participation subject to any applicable pre-existing conditions as outlined in the plan document.

3. Employees who terminate all employment with the state (not simply move from one agency to another) and are rehired as a new state employee before termination of participation, and their eligible dependents who were covered by the plan, will be eligible for participation immediately.

4. Employees who terminate all employment with the state (not simply move from one agency to another) and are rehired as a new state employee in the subsequent month, and their eligible dependents who were covered by the plan, will be eligible for participation retroactive to the date following termination of participation;

(P) Emancipated child(ren)—A child(ren) who is—

1. Employed on a full-time basis;

2. Eligible for group health benefits in his/her own behalf;

3. Maintaining a residence separate from his/her parents or guardian—except for full-time students in an accredited school or institution of higher learning; or

4. Married;

(Q) Employee and dependent participation—Participation of an employee and the employee's eligible dependents. Dependent participation may be further defined to include the participating employee's: 1) spouse only; 2) child(ren) only; or 3) spouse and child(ren). Any individual eligible for participation as an employee is not eligible as a dependent, except as noted in 22 CSR 10-2.020(1)(A)3.;

(R) Employee only participation—Participation of an employee without participation of the employee's dependents, whether or not the employee has dependents;

(S) Employees—Employees of the state and present and future retirees from state employment who meet the eligibility requirements as prescribed by state law;

(T) Employer—The state department that employs the eligible employee as defined above;

(U) Executive director—The administrator of the Missouri Consolidated Health Care Plan (MCHCP) who reports directly to the plan administrator;

(V) Health maintenance organization (HMO)—A plan that provides for a wide range of comprehensive health care services for a specified group at a fixed periodic prepayment;

(W) Home health agency—An agency certified by the Missouri Department of Health and Senior Services, or any other state's licensing or certifying body, to provide health care services to persons in their homes;

(X) Hospice—A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill;

(Y) Hospital.

1. An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24) hour-a-day nursing service by a registered nurse (RN) on duty or call.

2. An institution not meeting all the requirements of (1)(Y)1. of this rule, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

3. An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).

4. A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

5. A residential alcoholism, chemical dependency or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction. In no event shall the term hospital include a skilled nursing facility or any institution or part thereof which is used primarily as a skilled nursing facility, nursing home, rest home or facility for the aged;

(Z) Lifetime—The period of time you or your eligible dependents participate in the plan;

(AA) Medical benefits coverage—Services that are received from providers recognized by the plan and are covered benefits under the plan;

(BB) Medically necessary—Services and/or supplies usually rendered or prescribed for the specific illness or injury;

(CC) Nurse—A registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule;

(DD) Open enrollment period—A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year;

(EE) Out-of-area—Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria;

(FF) Out-of-network—Providers that do not participate in the member's health plan;

(GG) Participant—Any employee or dependent accepted for membership in the plan;

(HH) Physically or mentally disabled—The inability of a person to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition;

(II) Physician/Doctor—A licensed practitioner of the healing arts, acting within the scope of his/her practice as licensed under section 334.021, RSMo;

(JJ) Plan—The program of health care benefits established by the trustees of the Missouri Consolidated Health Care Plan as authorized by state law;

(KK) Plan administrator—The trustees of the Missouri Consolidated Health Care Plan;

(LL) Plan document—The statement of the terms and conditions of the plan as adopted by the plan administrator in the "2005 Missouri Consolidated Health Care Plan State Employee Member Handbook" and incorporated by reference in this rule, as published in August 2004 by the Missouri Consolidated Health Care Plan, PO Box 104355, Jefferson City, MO 65110. This rule does not incorporate any subsequent amendments or additions;

(MM) Plan year—Same as benefit year;

(NN) Point-of-service (POS)—A plan which provides a wide range of comprehensive health care services, like an HMO, if in-network providers are utilized, and like a PPO plan, if non-network providers are utilized;

(OO) Pre-admission testing—X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission;

(PP) Preferred provider organization (PPO)—An arrangement with providers where discounted rates are given to members of the plan who, in turn, are offered a financial incentive to use these providers;

(QQ) Prior plan—The terms and conditions of a plan in effect for the period preceding coverage in the MCHCP;

(RR) Provider—Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions and administrative guidelines of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized;

(SS) Review agency—A company responsible for administration of clinical management programs;

(TT) Second opinion program—A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service;

(UU) Skilled nursing facility (SNF)—An institution which meets fully each of the following requirements:

1. It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board and twenty-four (24) hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;

2. It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and

3. A skilled nursing facility shall be deemed to include institutions meeting the criteria in subsection (1)(UU) of this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97);

(VV) State—Missouri;

(WW) Subscriber—The employee or member who elects coverage under the plan;

(XX) Survivor—A member who meets the requirements of 22 CSR 10-2.020(5)(A);

(YY) Unemancipated child(ren)—A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-three (23) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

1. Stepchild(ren);

2. Foster child(ren) for whom the employee is responsible for health care;

3. Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care;

4. Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator. Except for a disabled child(ren) as described in subsection (1)(HH) of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-three (23) (see 22 CSR 10-2.020(3)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-three (23)); and

5. Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan;

(ZZ) Usual, customary, and reasonable charge—

1. Usual—The fee a physician most frequently charges the majority of his/her patients for the same or similar services;

2. Customary—The range of fees charged in a geographic area by physicians of comparable skills and qualifications for the same performance of similar service;

3. Reasonable—The flexibility to take into account any unusual clinical circumstances involved in performing a particular service; and

4. A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the doctors for ninety percent (90%) of the procedures reported; and

(AAA) Vested subscriber—A member who meets the requirements of 22 CSR 10-2.020(5)(B).

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Rescinded and readopted: Filed Dec. 20, 2004.*

PUBLIC COST: This proposed rule will cost the Missouri Consolidated Health Care Plan $321,006,312 annually in the aggregate.

PRIVATE COST: This proposed rule will cost private entities $71,839,704 annually in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson City, Mo 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. RULE NUMBER

Title: 22 – Missouri Consolidated Health Care Plan

Division: Division 10

Chapter: Chapter 2

Type of Rulemaking: Proposed Rule

Rule Number and Name: 22 CSR 10-2.010 Definitions

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Missouri Consolidated Health Care Plan	$321,006,312 annual

III. WORKSHEET

Estimated cost is the annual cost of the MCHCP providing health care plans to all state employees for calendar year 2005. The MCHCP is implementing a revised one plan benefit design. Under this arrangement, the member will pay the following:

$25 copayment for a physician office visit
$300 copayment for an inpatient hospitalization

IV. ASSUMPTIONS

1. Total enrollment as of mid-November 2004 (data used for CY05 projection);
2. Calendar year 2005 membership would remain relatively stable;
3. Calendar year 2005 rates based on projections of self-insured premiums as developed by the MCHCP's actuary;
4. State subsidies for active employees capped at the low cost plan; and
5. State subsidies for retirees based on the 2004 years of service policy.

FISCAL NOTE
PRIVATE COST

I. RULE NUMBER

Title: 22 – Missouri Consolidated Health Care Plan

Division: Division 10

Chapter: Chapter 2

Type of Rulemaking: Proposed Rule

Rule Number and Name: 22 CSR 10-2.010 Definitions

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
103,957 individuals enrolled in the MCHCP	Individuals enrolled in the MCHCP	$71,839,704 annual

III. WORKSHEET

Estimated cost is the annual cost for all the MCHCP subscribers' premium costs for calendar year 2005. The MCHCP is implementing a revised one plan benefit design. Under this arrangement, the member will pay the following:

$25 copayment for a physician office visit
$300 copayment for an inpatient hospitalization

IV. ASSUMPTIONS

1. Total enrollment as of mid-November 2004 (data used for CY05 projection);
2. Calendar year 2005 membership remains relatively stable;
3. Calendar year 2005 rates based on projections of self-insured premiums as developed by the MCHCP's actuary;
4. State subsidies for active employees capped at the low cost plan;
5. State subsidies for retirees based on the 2004 years of service policy;
6. Utilization data received from the health plans indicates that lower copayments essentially offset the higher premiums for those individuals previously enrolled in the standard plan design option;
7. For those individuals previously enrolled in the premium plan design option, the decreased rate savings should exceed the additional cost of the higher copayments; and
8. Actual costs for individual employees could vary based upon his/her actual utilization of services.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RESCISSION

22 CSR 10-2.020 Membership Agreement and Participation Period. This rule established the policy of the board of trustees in regard to the employee's membership agreement and membership period for participation in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded due to the filing of a new emergency and proposed rule.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Rescinded: Filed Dec. 20, 2004.*

PUBLIC COST: The fiscal impact of this proposed rescission is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Ron Meyer, P.O. Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RULE

22 CSR 10-2.020 Subscriber Agreement and General Membership Provisions

PURPOSE: This rule establishes the policy of the board of trustees in regard to the employee's membership agreement and membership period for participation in the Missouri Consolidated Health Care Plan.

(1) The participant's initial application, any subsequently accepted modifications to such application, and the plan document as adopted by the board along with duly executed amendments shall comprise the subscriber agreement between the participant and the Missouri Consolidated Health Care Plan (MCHCP). Any associated administrative guidelines interpret the subscriber agreement for the benefit of members and administrators but are not a part of the subscriber agreement.

(A) By applying for coverage under the MCHCP a participant agrees that—

1. The employer may deduct the cost of the premium for the employee's plan from the employee's paychecks;

2. Individual and family deductibles, if appropriate, will be applied; and

3. Any individual eligible as an employee shall not be covered as a dependent unless the employee is on an approved leave of absence.

(2) The effective date of participation shall be determined, subject to the effective date provision in subsection (2)(C), as follows:

(A) Employee Participation.

1. If application by an employee is made on or before the date of eligibility, participation shall become effective on such date of eligibility;

2. If application by an employee is made within thirty-one (31) days after the date of eligibility, participation may become effective on the date of eligibility or the first day of the calendar month coinciding with or following the date of application, except that participation shall be retroactive to the beginning of the month for employees rehired during the month following the month participation would have terminated; and

3. Not limiting or excluding any of the other provisions, if application is not made within thirty-one (31) days of the employee's date of eligibility, they may apply for coverage only if a life event occurs. Life events include: marriage, birth, adoption, death, divorce, legal separation, job loss or failure to elect continuation of coverage. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event;

(B) Dependent Coverage. Dependent participation cannot precede the subscriber's participation. Application for participants must be made in accordance with the following provisions. For family coverage, once a subscriber is participating with respect to dependents, newly acquired dependents are automatically covered on their effective dates as long as the plan administrator is notified within thirty-one (31) days of the person becoming a dependent. First eligible dependents must be added within thirty-one (31) days of such qualifying event. The employee is required to notify the plan administrator on the appropriate form of the dependent's name, date of birth, eligibility date and Social Security number, if available. Claims will not be processed until the required information is provided.

1. If an employee makes concurrent application for dependent participation on or before the date of eligibility or within thirty-one (31) days thereafter, participation for dependent will become effective on the date the employee's participation becomes effective;

2. When an employee participating in the plan first becomes eligible with respect to a dependent child(ren), coverage may become effective on the eligibility date or the first day of the month coinciding with or following the date of eligibility if application is made within thirty-one (31) days of the date of eligibility and provided any required contribution for the period is made;

3. Unless required under federal guidelines—

A. An emancipated dependent who regains his/her dependent status is immediately eligible for coverage if an application is submitted within thirty-one (31) days of regaining dependent status; and

B. An eligible dependent that is covered under a spouse's health plan who loses eligibility under the criteria stipulated for dependent status under the spouse's health plan is not eligible for coverage until the next open enrollment period. (Note: Subparagraphs (2)(B)3.A. and B. do not include dependents of retirees or long-term disability members covered under the plan); and

4. Survivors, retirees, vested subscribers and long-term disability subscribers may only add dependents to their coverage when the dependent is first eligible for coverage;

(C) Effective Date Proviso.

1. In any instance when the employee is not actively working full-time on the date participation would otherwise have become effective, participation shall not become effective until the date the employee returns to full-time active work;

(D) Application for dependent coverage may be made at other times of the year when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's: 1) employment is terminated or is no longer eligible for coverage under his/her employer's plan, or 2) employer-sponsored medical plan is terminated. With respect to dependent child(ren) coverage, application may also be made at other times of the year when the member receives a court order stating s/he is responsible for providing medical coverage for the dependent child(ren) or when the dependent loses Medicaid coverage. Dependents added under any of these exceptions must supply verification from the previous insurance carrier or the member's employer that they have lost coverage and the effective date of termination. Coverage must also be requested within sixty (60) days from the termination date of the previous coverage. Application must be made within sixty (60) days of the court order. (Note: This section does not include dependents of retirees, survivors, vested subscribers, or long-term disability subscribers covered under the plan);

(E) When an employee experiences applicable life events, eligibility will be administered according to Health Insurance Portability and Accountability Act (HIPAA) guidelines.

(3) Termination of participation shall occur on the last day of the calendar month coinciding with or following the happening of any of the following events, whichever shall occur first:

(A) Written request by the employee;

(B) Failure to make any required contribution toward the cost of coverage;

(C) Entry into the armed forces of any country. With respect to an employee, membership in the National Guard or Reserves with or without two (2) consecutive full weeks of active training each year shall not be considered as entry into the armed forces; or

(D) Termination of Eligibility for Participation.

1. With respect to employees, termination of participation shall occur upon termination of employment in a position covered by the MCHCP, except as specified in sections (4) and (5).

2. With respect to dependents, termination of participation shall occur upon ceasing to be a dependent as defined in this rule with the following exception: unemancipated mentally retarded and/or physically handicapped children will continue to be eligible beyond age twenty-three (23) during the continuance of a permanent disability provided documentation satisfactory to the plan administrator is furnished by a physician prior to the dependent's twenty-third birthday, and as requested at the discretion of the plan administrator.

3. Termination of employee's participation shall terminate the participation of dependents, except as specified in section (5).

(4) Termination of participation shall occur immediately upon discontinuance of the plan subject to the plan termination provision specified in 22 CSR 10-2.080(1).

(5) Continuation of Coverage.

(A) Dependents. Termination of an active employee's participation by reason of death shall not terminate participation with respect to the surviving spouse and/or dependent children if—

1. The active employee was vested and eligible for a future retirement benefit; or

2. Your eligible dependents meet one (1) of the following conditions:

A. They have had coverage through MCHCP since the effective date of the last open enrollment period;

B. They have had other health insurance for the six (6) months immediately prior to your death—proof of insurance is required; or

C. They have had coverage through MCHCP since they were first eligible.

(B) Employee Eligible for Retirement Benefits. Any employee who, at the time of termination of employment, met the following—

1. Eligibility criteria:

A. Coverage through MCHCP since the effective date of the last open enrollment period;

B. Other health insurance for the six (6) months immediately prior to the termination of state employment—proof of insurance is required; or

C. Coverage since first eligible;

2. Immediately eligible to receive a monthly retirement benefit from the Missouri State Employees' Retirement System, Public School Retirement System, the retirement system of a participating public entity, or the Highway Retirement System may elect to continue to participate in the plan by paying the cost of plan benefits as determined by the plan administrator. An employee must apply for continued coverage within thirty-one (31) days of the first day of the month following the date of retirement. An employee, continuing coverage under this provision, may also continue coverage for eligible dependents.

A. If a member participates in the MCHCP as a vested member, his/her dependents may also participate if they meet one (1) of the following criteria:

(I) They have had coverage through MCHCP since the effective date of the last open enrollment period;

(II) They have had other health insurance for the six (6) months immediately prior to state employment termination—proof of insurance is required; or

(III) They have had coverage since they were first eligible;

3. In the case of the death of a retiree who was maintaining dependent coverage under this provision, the dependent of the deceased retiree may continue his/her participation under the plan. However, retirees, survivors, vested subscribers and long-term disability subscribers and their dependents are not later eligible if they discontinue their coverage at some future time, except as noted in (5)(B)4.; and

4. A vested or retired member may elect to suspend their coverage upon entry into the armed forces of any country by submitting a copy of their activation papers within thirty-one (31) days of their activation date. Coverage will be suspended the first of the month following the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of their separation papers and a completed enrollment form within thirty-one (31) days of their separation date. Coverage will be reinstated as of the first of the month following the month of separation.

(C) Coverage at Termination. A former employee may participate in the plan if s/he terminates employment before retirement provided s/he is a vested employee. This means s/he will be eligible for a benefit from the Missouri State Employees' Retirement System, the Public School Retirement System, the retirement system of a participating public entity or the Highway Retirement System when s/he reaches retirement age. Coverage may also be continued by a member of the general assembly, a state official holding a statewide elective office, or an employee employed by an elected state official or member of the general assembly whose employment is terminated because the state official or member of the general assembly ceases to hold elective office. The election to participate must be made within thirty-one (31) days from the last day of the month in which employment terminated. The member must pay the full cost of coverage. However, s/he will not later be eligible if s/he discontinues coverage at some future time.

(D) Leave of Absence. An employee on approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify the plan administrator of the leave of absence and any extension of the leave of absence by submitting the required form. Any employee on an approved leave of absence who was a member of the Missouri Consolidated Health Care Plan when the approved leave began, but who subsequently terminated participation in the Missouri Consolidated Health Care Plan while on leave, may recommence his/her coverage in the plan at the same level (employee only,

or employee and dependents) upon returning to employment directly from the leave, but they will be subject to preexisting limitations, when applicable. Preexisting limitations under this provision will not apply to health maintenance organization (HMO) or point-of-service (POS) members. However, eligibility is terminated for those members receiving a military leave of absence, as specified in subsection (3)(C). Coverage may be reinstated upon return from military leave without proof of insurability or preexisting conditions. However, the former member must complete an enrollment form. Coverage under this provision is effective on the first of the month coinciding with or following the employee's return to work. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date and timely requests reinstatement of coverage.

(E) Layoff. An employee on layoff status may elect to retain eligibility to participate in the plan by paying the required contribution for a maximum of twenty-four (24) months with recertification of status at least every twelve (12) months by the employing department. Eligibility will terminate if the employee becomes eligible for health benefits as an employee of another employer. If participation terminates and the employee is recalled to service, eligibility will be as a new employee.

(F) Workers' Compensation. Any person who is receiving, or is entitled to receive, Workers' Compensation benefits as a result of an injury or accident sustained in employment and who was a member of the plan at the time of becoming disabled may continue his/her coverage in the plan at the same level of participation (employee only or employee and dependents) by paying the required contributions, if the disability occurred in the employment through which the employee qualifies for membership in the plan. Any person receiving, or entitled to receive, Workers' Compensation benefits who was a member of the plan at the time of becoming disabled as a result of an injury or accident sustained in employment through which the person qualified for membership in the plan, but who subsequently terminated participation in the plan, may recommence his/her coverage in the plan at the same level (employee only, or employee and dependents) upon returning to employment, without proving insurability.

(G) Reinstatement After Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action available as a recourse through his/her employer, s/he will be allowed to reinstate his/her medical benefit retroactively to the date of dismissal. If the employee is reinstated with back pay, s/he will be responsible for paying any contribution normally made for either his/her coverage or his/her covered dependents. No preexisting condition limitation will apply. If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making any required contribution toward the cost of his/her medical benefits. If the employee does not purchase coverage for the period between termination and reinstatement, s/he may regain the same level of coverage s/he had prior to termination. If the employee participates in a preferred provided organization (PPO) plan, the preexisting condition limitation will apply if coverage lapsed more than sixty-three (63) days. This does not apply if the employee participates in an HMO or POS.

(6) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) In accordance with the COBRA, eligible employees and their dependents may continue their medical coverage after the employee's termination date.

1. Employees terminating for reasons other than gross misconduct may continue coverage for themselves and their covered dependents for eighteen (18) months at their own expense.

2. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

3. A divorced spouse may continue coverage at his/her own expense for up to thirty-six (36) months if the plan administrator is notified within sixty (60) days from the date coverage would terminate.

4. Dependent spouse and/or child(ren) may continue coverage up to thirty-six (36) months if the covered employee retires and the dependent spouse/child(ren) has not been covered by the plan for two (2) years.

5. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense if the plan administrator is notified within sixty (60) days of the loss of the dependent's eligibility.

6. Employees who are disabled at termination or become disabled during the first sixty (60) days of coverage may continue coverage for up to twenty-nine (29) months.

7. Premiums for continued coverage will be one hundred two percent (102%) of the health plan rate, one hundred fifty percent (150%) if disabled. Once coverage is terminated under the COBRA provision it cannot be reinstated.

8. All operations under the COBRA provision will be applied in accordance with federal regulations.

(7) Missouri State Law COBRA Wrap-Around Provisions—Missouri law provides that if you lose your group health insurance coverage because of a divorce, legal separation or the death of your spouse you may continue coverage until age sixty-five (65) if: a) You continue and maintain coverage under the thirty-six (36)-month provision of COBRA; and b) You are at least fifty-five (55) years old when your COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay all of the application premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium. The above Cancellation of Continuation Coverage also applies to COBRA wrap-around continuation.

(8) Medicare—Participants eligible for Medicare who are not eligible for this plan as their primary plan, shall be eligible for benefits no less than those benefits for participants not eligible for Medicare. For such participants who elect to continue their coverage, benefits of this plan shall be coordinated with Medicare benefits on the then standard coordination of benefits basis to provide up to one hundred percent (100%) reimbursement for covered charges.

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, an estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim submitted basis so that if, for a given claim, Medicare reimbursement was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims; and

(B) If any retired participants or long-term disability recipients, their eligible dependents or surviving dependents eligible for coverage elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Rescinded and readopted: Filed Dec. 20, 2004.*

PUBLIC COST: The fiscal impact of this proposed rule is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RESCISSION

22 CSR 10-2.030 Contributions. This rule established the policy of the board of trustees in regard to the contributions made to the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded due to the filing of a new emergency and proposed rule.

*AUTHORITY: section 103.059, RSMo 1994. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Rescinded: Filed Dec. 20, 2004.*

PUBLIC COST: The fiscal impact of this proposed rescission is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson CIty, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RULE

22 CSR 10-2.030 Contributions

PURPOSE: This rule establishes the policy of the board of trustees in regard to the contributions made to the Missouri Consolidated Health Care Plan.

(1) Total premium costs for various classes of employee participation based on employment status, eligibility for Medicare and for various classifications of dependent participation are established by the plan administrator.

(2) The contribution by the employee shall be determined by the plan administrator for state employees.

(3) Refunds of overpayments are limited to the amount overpaid during the twelve (12)-month period ending at the end of the month preceding the month during which notice of overpayment is received.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the **Code of State Regulations**. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Rescinded and readopted: Filed Dec. 20, 2004.*

PUBLIC COST: The fiscal impact of this proposed rule is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RESCISSION

22 CSR 10-2.045 Co-Pay and PPO Plan Summaries. This rule established the policy of the board of trustees in regard to the medical benefits for participation in the Missouri Consolidated Health Care Plan Co-Pay Plan.

PURPOSE: This rule is being rescinded due to the filing of a new emergency and proposed rule.

*AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the **Code of State Regulations**. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Rescinded: Filed Dec. 20, 2004.*

PUBLIC COST: The fiscal impact of this proposed rescission is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RULE

22 CSR 10-2.045 Plan Utilization Review Policy

PURPOSE: This rule establishes the policy of the board of trustees in regard to the utilization review of the Missouri Consolidated Health Care Plan Medical Plans.

(1) Clinical Management—Certain benefits are subject to a utilization review (UR) program. The program consists of four (4) parts, as described in the following:

(A) Precertification—The medical necessity of a non-emergency hospital admission, specified procedures as documented in the claims administrator's guidelines, and/or skilled nursing services provided on an inpatient basis must be prior authorized by the appropriate review agency. For emergency hospital admissions, the review agency must be notified within forty-eight (48) hours of the admission. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(B) Concurrent Review—The review agency will continue to monitor the medical necessity of the admission and approve the continued stay in the hospital. Retirees and other participants for whom Medicare is the primary payor are not subject to this provision;

(C) Large Case Management—Members that require long-term acute care may be offered the option of receiving the care, if appropriate, in a more cost-effective setting such as a skilled nursing facility or their own home. In some cases this may require coverage for benefits that normally are not covered under the plan. These benefits may be provided through the approval of the claims administrator;

(D) Hospital Bill Audits—Certain hospital bills will be subject to review to verify that the services billed were actually provided and/or the associated billed amounts are accurate and appropriate; and

(E) Penalties—Members not complying with subsections (1)(A) and (B) of this rule may be subject to a financial penalty in connection with their covered benefits. (Note: The utilization review program will be operated in accordance with the administrative guidelines.)

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Rescinded and readopted: Filed Dec. 20, 2004.*

PUBLIC COST: The fiscal impact of this proposed rule is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer. PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RESCISSION

22 CSR 10-2.055 Co-Pay and PPO Plan Benefit Provisions and Covered Charges. This rule established the policy of the board of trustees in regard to the benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan Co-Pay Plan.

PURPOSE: This rule is being rescinded due to the filing of a new emergency and proposed rule.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Rescinded: Filed Dec. 20, 2004.*

PUBLIC COST: The fiscal impact of this proposed rescission is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RULE

22 CSR 10-2.055 Medical Plan Benefit Provisions and Covered Charges

PURPOSE: This rule establishes the policy of the board of trustees in regard to the benefit provisions and covered charges for participation in the Missouri Consolidated Health Care Plan Co-Pay Plan.

(1) Benefit Provisions.

(A) Subject to the plan provisions and limitations and the written application of the employee, the benefits are payable for covered charges incurred by a participant while covered under the co-pay or preferred provider organization (PPO) plan, provided the deductible requirement, if any, is met.

(B) Any deductible requirement applies each calendar year to covered charges. The requirement is met as soon as covered charges incurred in a calendar year, which are not paid in part or in whole by the plan, equals the deductible amount.

(C) Any family deductible requirement is met as soon as covered charges in a calendar year, which are not paid in part or in whole by the plan, equals the family deductible requirement.

(D) The total amount of benefits payable for all covered charges incurred out-of-network during an individual's lifetime shall not exceed the lifetime maximum.

(E) If both husband and wife are participating separately as employees under this plan, the family deductible and benefit features shall nevertheless apply to the benefit of the family unit.

(2) Covered Charges.

(A) Only charges for those services which are incurred as medical benefits and supplies which are medically necessary and customary, including normally covered charges arising as a complication of a noncovered service, and which are:

1. Prescribed by a doctor or provider for the therapeutic treatment of injury or sickness;
2. To the extent they do not exceed any limitation;
3. Not excluded by the limitations; and
4. For not more than the usual, reasonable, and customary charge as determined by the claims administrator for the services provided, will be considered covered charges.

(B) To determine if services and/or supplies are medically necessary and customary and if charges are not more than usual, reasonable, and customary, the claims administrator will consider the following:

1. The medical benefits or supplies usually rendered or prescribed for the condition; and
2. The usual, reasonable, and customary charges in the area in which services and/or supplies are provided.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 12, 2000, effective Jan. 1, 2001, expired June 29, 2001. Original rule filed Dec. 12, 2000, effective June 30, 2001. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Rescinded and readopted: Filed Dec. 20, 2004.*

PUBLIC COST: The fiscal impact of this proposed rule is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RESCISSION

22 CSR 10-2.070 Coordination of Benefits. This rule established the policy of the board of trustees in regard to coordination of benefits in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded due to the filing of a new emergency and proposed rule.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Rescinded: Filed Dec. 20, 2004.*

PUBLIC COST: The fiscal impact of this proposed rescission is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson CIty, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RULE

22 CSR 10-2.070 Coordination of Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to coordination of benefits in the Missouri Consolidated Health Care Plan.

(1) If a participant is also covered under any other plan (as defined here) and is entitled to benefits or other services for which benefits are payable under this plan, the benefits under this plan will be adjusted as shown in this rule.

(2) As used in this rule—

(A) Plan means a plan listed in the following which provides medical, vision, dental or other health benefits or services:

1. A group or blanket plan on an insured basis;
2. Other plan which covers people as a group;
3. A self-insured or non-insured plan or other plan which is arranged through an employer, trustee or union;
4. A prepayment group plan which provides medical, vision, dental or health service;
5. Government plans, including Medicare;
6. Auto insurance when permitted by the laws of the state of jurisdiction; and
7. Single- or family-subscribed plans issued under a group- or blanket-type plan;

(B) The definition of plan shall not include:

1. Hospital preferred provider organization (PPO) type plans;
2. Types of plans for students; or
3. Any individual policy or plan;

(C) Each plan, as defined previously, is a separate plan. However, if only a part of the plan reserves the right to adjust its benefits due to other coverage, the portion of the plan which reserves the right and the portion which does not shall be treated as separate plans;

(D) Allowable expense means a necessary, reasonable and customary item of medical, vision, dental or health expense which is covered at least in part under one of the plans. If a plan provides benefits in the form of services, the cash value of such service will be deemed to be the benefit paid. An allowable expense to a secondary plan includes the value or amount of any allowable expense which was not paid by the primary or first paying plan; and

(E) Benefit determination period means from January 1 of one year through December 31 of the same year.

(3) The benefits under the policy shall be subject to the following:

(A) This provision shall apply in determining the benefit as to a person covered under the policy for a benefit determination period if the sum of paragraphs (3)(A)1. and 2. listed in this rule exceeds the allowable expense incurred by or on behalf of such person during the period—

1. The benefits payable under this plan in the absence of this provision; and

2. The benefits payable under all other plans in the absence of provisions similar to this one;

(B) As to any benefit determination period, the allowable expense under this plan shall be coordinated, except as provided in subsection (3)(C) of this rule, so that the sum of such benefits and all of the benefits paid, payable or furnished which relate to such allowable expense under other plans, shall not exceed the total of allowable expenses incurred by the covered individual. All benefits under other plans shall be taken into account whether or not claim has been made;

(C) If coverage under any other plan is involved, as shown in subsection (3)(B) of this rule—

1. This plan contains a provision coordinating benefits with other plans; and

2. The terms set forth in subsection (2)(D) would require benefits under this plan be figured before benefits under the other plan are figured, the benefits under this plan will be determined as though other plans were not involved;

(D) The basis for establishing the order in which plans determine benefits shall be as follows:

1. Benefits under the plan which cover the person on whom claim is based as an employee shall be determined before the benefits under a plan which cover the person as a dependent; and

2. The primary plan for dependent children will be the plan of the parent whose birthday occurs first in the calendar year. If both parents have the same birthday, the plan of the person who has been covered the longest period of time becomes the primary carrier:

A. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of the plan which covers the child as a dependent of the parent without custody;

B. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody; and

C. In spite of subparagraphs (3)(D)2.A. and B. of this rule, if there is a court decree which would otherwise decide financial duty for the medical, vision, dental or health care expenses for the child, the benefits of a plan which covers the child as a dependent of the parent with such financial duty shall be decided before the benefits of any other plan which covers the child as a dependent; and when paragraphs (3)(D)1. and 2. of this rule do not establish the order of benefit determination, the plan which covers the person for the longer time shall be determined first; and

(E) When this provision operates to reduce the benefits under this plan, each benefit that would have otherwise been paid will be reduced proportionately and this reduced amount shall be charged against the benefit limits of this plan.

(4) When a member has coverage with two (2) group plans, the plan which covers the person for the longer time shall be determined first.

(5) If a member is eligible for Medicare due to a disability, Medicare is the primary plan and this plan is a secondary plan. If a member or dependent is eligible for Medicare due to end stage renal disease, this plan is primary for the first thirty (30) months. Medicare is primary after the first thirty (30) months.

(6) The claims administrator, with the consent of the employee or the employee's spouse when the claim is for a spouse, or the parent or guardian when the claim is for a minor child, may release or obtain any data which is needed to implement this provision.

(7) When payments should have been paid under this plan but were already paid under some other plan, the claims administrator shall have the right to make payment to such other plan of the amount which would satisfy the intent of this provision. This payment shall discharge the liability under this plan.

(8) When payments made under this plan are in excess of the amount required to satisfy the intent of this provision, the claims administrator shall have the right to recover the excess payment from one (1) or more of the following:

(A) Any person to whom, for whom or with respect to whom these payments were made;

(B) Any insurance company; or

(C) Any other organization.

(9) The claims administrator will pay benefits promptly, or, if applicable, within their contractual time frame obligations after submittal of due proof of loss unless the claims administrator provides the claimant a clear, concise statement of a valid reason for further delay which is in no way connected with, or caused by the existence of this provision nor otherwise caused by the claims administrator.

(10) If one of the other plans involved (as defined in coordination of benefits provision) provides benefits on an excess insurance or excess coverage basis, subsections (3)(C) and (D) of this rule shall not apply to the plan and this policy will pay as excess coverage.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Rescinded and readopted: Filed Dec. 20, 2004.*

PUBLIC COST: The fiscal impact of this proposed rule is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RESCISSION

22 CSR 10-2.075 Review and Appeals Procedure. This rule established the policy of the board of trustees in regard to review and

appeals procedures for participation in the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded due to the filing of a new emergency and proposed rule.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Rescinded: Filed Dec. 20, 2004.*

PUBLIC COST: The fiscal impact of this proposed rescission is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RULE

22 CSR 10-2.075 Review and Appeals Procedure

PURPOSE: This rule establishes the policy of the board of trustees in regard to review and appeals procedures for participation in the Missouri Consolidated Health Care Plan.

(1) When any participant shall suffer any injury or sickness giving rise to claim under these rules, s/he shall have free choice of providers practicing legally in the location in which service is provided to the end that a provider/patient relationship shall be maintained. Reimbursement will be in accordance with the benefit provisions of the type of coverage chosen by the participant.

(2) The plan administrator, agent or claims administrator, upon receipt of a notice of request, shall furnish to the employee the forms as are usually furnished for filing proofs of loss. If the forms are not furnished within thirty (30) days after the giving of such notice, the employee shall be deemed to have complied with the requirement as to proof of loss upon submitting, within the time fixed for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which request is made.

(3) Written proof of claims incurred should be furnished to the claims administrator as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the claims administrator before they are paid.

(4) In the case of medical benefits, the claims administrator will send written notice of any amount applied toward the deductible as well as any payments made. The claims administrator may also send a request for additional information or material to support the claim, along with reasons why this information is necessary.

(5) All members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the health maintenance organization (HMO), point-of-service (POS), preferred provider organization (PPO) or co-pay health plan contractor or claims administrator applicable to the member. Only after these procedures have been exhausted may the member appeal directly to the Missouri Consolidated Health Care Plan Board of Trustees to review the decision of the health plan contractor or claims administrator.

(A) Appeals to the board of trustees shall be submitted in writing within forty-five (45) days of receiving the final decision from the member's health care plan contractor or claims administrator, specifically identifying the issue to be resolved and be addressed to:

Attn: Appeal
Board of Trustees
Missouri Consolidated Health Care Plan
PO Box 104355
Jefferson City, MO 65110

(B) The board may utilize a hearing officer, such as the Administrative Hearing Commission, to conduct a fact-finding hearing, and make proposed findings of fact and conclusions of law.

1. The hearing will be scheduled by the MCHCP.

2. The parties to the hearing will be the insured and the applicable health plan.

3. All parties shall be notified in writing of the date, time and location of the hearing.

4. All parties shall have the right to appear at the hearing and submit written or oral evidence. The appealing party shall be responsible for all copy charges incurred by MCHCP in connection with any documentation that must be obtained through the MCHCP. These fees will be reimbursed should the party prevail in his/her appeal. They may cross-examine witnesses. They need not appear and may still offer written evidence. The strict rules of evidence shall not apply.

5. The party appealing to the board shall carry the burden of proof.

6. The independent hearing officer shall propose findings of fact and conclusions of law, along with its recommendation, to the board. Copies of the summary, findings, conclusions and recommendations shall be sent to all parties.

(C) The board may, but is not required, to review the transcript of the hearing. It will review the summary of evidence, the proposed findings of fact and conclusions of law and shall then issue its final decision on the matter.

1. All parties shall be given a written copy of the board's final decision.

2. All parties shall be notified that if they feel aggrieved by the final decision, they shall have the right to seek judicial review of the decision within thirty (30) days of its receipt, as provided in sections 536.100 to 536.140, RSMo.

(D) Administrative decisions made solely by MCHCP may be appealed directly to the board of trustees, by either a member or health plan contractor providing a fully-insured product.

1. All the provisions of this rule, where applicable, shall apply to these appeals.

2. The parties to such appeal shall be the appellant and the MCHCP shall be respondent.

3. The appellant, if aggrieved by the final decision of the board, shall have the right of appeal as stated in subsection (5)(C) herein.

4. In reviewing these appeals, the board and/or staff may consider:

A. Newborns—

(I) Notwithstanding any other rule, if a member currently has children coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within six (6) months of the child's date of birth. If a member does not currently have children coverage under the plan but states that the required information was provided within the thirty-one (31)-day enrollment period, he/she must sign an affidavit stating that their information was provided within the required time period. The affidavit must be notarized and received in the MCHCP office within thirty-one (31) days after the date of notification from the MCHCP; and

(II) Once the MCHCP receives the signed affidavit from the member, coverage for the newborn will be backdated to the date of birth, if the request was made within six (6) months of the child's date of birth. The approval notification will include language that the MCHCP has no contractual authority to require the contractors to pay for claims that are denied due to the retroactive effective date. If an enrollment request is made under either of these two (2) scenarios past six (6) months following a child's date of birth, the information will be forwarded to the MCHCP board for a decision.

B. Credible evidence—Notwithstanding any other rule, the MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office or the MCHCP, that was no fault of the member.

C. Change of plans due to dependent change of address—A member may change plans outside the open enrollment period if his/her covered dependents move out of state and their current plan cannot provide coverage.

(E) Any member wishing to appeal their enrollment selection completed during the annual open enrollment period must do so in writing to the board of trustees within thirty (30) calendar days of the beginning of the new plan year. The MCHCP will respond within thirty (30) calendar days of the receipt of the appeal.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 13, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 21, 1994, effective June 30, 1995. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Rescinded and readopted: Filed Dec. 20, 2004.*

PUBLIC COST: The fiscal impact of this proposed rule is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—Plan Options

PROPOSED RESCISSION

22 CSR 10-2.080 Miscellaneous Provisions. This rule established the policy of the board of trustees in regard to miscellaneous provisions under the Missouri Consolidated Health Care Plan.

PURPOSE: This rule is being rescinded due to the filing of a new emergency and proposed rule.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Rescinded: Filed Dec. 20, 2004.*

PUBLIC COST: The fiscal impact of this proposed rescission is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rescission will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RULE

22 CSR 10-2.080 Miscellaneous Provisions

PURPOSE: This rule establishes the policy of the board of trustees in regard to miscellaneous provisions under the Missouri Consolidated Health Care Plan.

(1) Termination of the Plan. Any other provision of this plan to the contrary notwithstanding, no benefit will be paid for charges incurred by a participant or former participant after the termination of this plan.

(2) Facility of Payment. Plan benefits will be paid to the employee if living and capable of giving a valid release for the payment due. If the participant, while living, is physically, mentally or for any other reason incapable of giving a valid release for any payment due, the claims administrator at his/her option, unless and until request is made by the duly appointed guardian, may pay benefits which may become due to any blood relative or relative connected by marriage to the participant, or to any other person or institution appearing to the claims administrator to have assumed responsibility for the affairs of the participant. Any payments made by the claims administrator in good faith pursuant to this provision shall fully discharge the claims administrator to the extent of the payment. Any benefit unpaid at the time of the employee's death will be paid to the employee's estate. If any benefits shall be payable to the estate of the employee, the claims administrator may pay these benefits to any relative by blood or connection by marriage of the employee who is deemed by the claims administrator to be equitably entitled to it. Any payments made by the claims administrator in good faith pursuant to this provision shall fully discharge the claims administrator to the extent of this payment.

Subject to any acceptable written direction and assignment by the employee, any benefits provided, at the claims administrator's option, may be paid directly to an eligible provider rendering covered services; but it is not required that the service be rendered by a particular provider.

(3) Confidentiality of Records. The health records of the participants in the plan are confidential and shall not be disclosed to any person, except pursuant to a written request by, or with the prior written consent of, the individual to whom the records pertain, unless disclosure of the records would be to the officers and employees of the plan or claims administrator or his/her legal representatives who have a need for the records in the performance of their duties; or unless disclosure would be for a routine use by the plan or claims administrator for a purpose which is compatible with the purpose for which it was collected; or unless disclosure of the records would be to the commissioner of administration, or his/her legal representative, for the sole purpose of preventing fraudulent or redundant medical claims to either the Missouri Consolidated Health Care Plan, Missouri, or other public entities as an employer or self-insurer of Workers' Compensation for use in the investigation of a Workers' Compensation claim; or unless disclosure of the records is to the participant to whom the record pertains; or unless disclosure of the record is pursuant to the order of a court of competent jurisdiction. The parent of any minor, or the legal guardian of any individual who has been declared to be incompetent due to physical or mental incapacity by a court of competent jurisdiction, may act on behalf of the individual.

(4) Should any provision of this plan conflict with the requirements of federal or state law, including but not limited to the Health Insurance Portability and Accountability Act, Family and Medical Leave Act, the Americans with Disabilities Act or the Older Workers Benefit Protection Act, the plan shall be administered in such a way as to comply with the requirements of law, and will be deemed amended to conform with law.

(5) This document will be kept on file at the principal offices of the plan administrator and may be inspected by a participant during regular business hours. Also, the plan administrator reserves the right at any time to modify or amend, in whole or in part, any or all provisions of the plan.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, please consult the ***Code of State Regulations****. Emergency rescission and rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Rescinded and readopted: Filed Dec. 20, 2004.*

PUBLIC COST: The fiscal impact of this proposed rule is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RULE

22 CSR 10-3.010 Definitions

PURPOSE: This rule establishes the policy of the board of trustees regarding the key terms within the Missouri Consolidated Health Care Plan relative to public entities and public entity members.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) When used in this chapter's rules or the public entity member handbook, these words and phrases have the meaning—

(A) Accident—An unexpected happening resulting in an injury which is not due to any fault or misconduct on the part of the person injured;

(B) Actively at work—You are considered actively at work when performing in the customary manner all of the regular duties of your occupation with the employer either at one (1) of the employer's regular places of business or at some location which the employer's business requires you to travel to perform your regular duties or other duties assigned by your employer. You are also considered to be actively at work on each day of a regular paid vacation or nonworking day on which you are not totally disabled, but only if you are performing in the customary manner all of the regular duties of your occupation with the employer on the immediately preceding regularly scheduled workday;

(C) Administrative guidelines—The interpretation of the plan document as approved by the plan administrator, developed for administration of the plan. The administrative guidelines may be changed upon approval of the executive director or his/her designee. Benefits provided shall be those in effect at the time services are rendered;

(D) Automatic reinstatement maximum—The maximum annual amount that can be reinstated to an individual's lifetime benefit;

(E) Benefit year—The twelve (12)-month period beginning January 1 and ending December 31;

(F) Benefits—Amounts payable by the plan as determined by the schedule of benefits and their limitations and exclusions as interpreted by the plan administrator;

(G) Care Support Program—A voluntary program that helps manage a chronic condition with outpatient treatment;

(H) Claims administrator—An organization or group responsible for the processing of claims and associated services for the plan's self-insured benefit programs and preferred provider organization (PPO);

(I) Cosmetic surgery—A procedure performed primarily to preserve or improve appearance rather than restore the anatomy and/or function of the body which are lost or impaired due to illness or injury;

(J) Covered benefits—A schedule of covered services and charges, including chiropractic services, which are payable under the plan;

(K) Custodial care—Care designed essentially to assist an individual to meet the activities of daily living; for example, assistance in bathing, supervision of medication which can usually be self-administered and which does not entail or require the continuing attention of trained medical or paramedical personnel;

(L) Dependent-only participation—Participation of certain survivors of employees. Dependent participation may be further defined to include the deceased employee's: 1) spouse only; 2) child(ren) only; or 3) spouse and child(ren);

(M) Dependents—The lawful spouse of the employee, the employee's unemancipated child(ren) and certain survivors of employees, as

provided in the plan document and these rules, for whom application has been made and has been accepted for participation in the plan;

(N) Eligibility date—Refer to 22 CSR 10-3.020 for effective date provisions.

1. Newly-hired employees and their eligible dependents, or employees rehired after their participation terminates and their eligible dependents, are eligible to participate in the plan on the first day of the month following the employee's date of eligibility as determined by the employer.

(O) Emancipated child(ren)—A child(ren) who is—

1. Employed on a full-time basis;

2. Eligible for group health benefits in his/her own behalf;

3. Maintaining a residence separate from his/her parents or guardian—except for full-time students in an accredited school or institution of higher learning; or

4. Married;

(P) Employee and dependent participation—Participation of an employee and the employee's eligible dependents. Dependent participation may be further defined to include the participating employee's: 1) spouse only; 2) child(ren) only; or 3) spouse and child(ren). Any individual eligible for participation as an employee is not eligible as a dependent, except as noted in 22 CSR 10-3.030(1)(A)9.;

(Q) Employee only participation—Participation of an employee without participation of the employee's dependents, whether or not the employee has dependents;

(R) Employees—Employees of the participating public entity and present and future retirees from the participating public entity who meet the eligibility requirements as prescribed by the participating public entity;

(S) Employer—The public entity that employs the eligible employee as defined above;

(T) Executive director—The administrator of the Missouri Consolidated Health Care Plan (MCHCP) who reports directly to the plan administrator;

(U) Health maintenance organization (HMO)—An organization that provides for a wide range of comprehensive health care services for a specified group at a fixed periodic prepayment;

(V) Home health agency—An agency certified by the Missouri Department of Health and Senior Services, or any other state's licensing or certifying body, to provide health care services to persons in their homes;

(W) Hospice—A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill;

(X) Hospital.

1. An institution operated pursuant to law and primarily engaged in providing on an inpatient basis medical, diagnostic and surgical facilities, all of which must be provided on its premises, under the supervision of a staff of one (1) or more physicians and with twenty-four (24) hour-a-day nursing service by a registered nurse (RN) on duty or call.

2. An institution not meeting all the requirements of (1)(X)1. of this rule, but which is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations.

3. An institution operated principally for treating sick and injured persons through spiritual means and recognized as a hospital under Part A, Hospital Insurance Benefits for the Aged of Medicare (Title I of Public Law 89-97).

4. A psychiatric residential treatment center accredited by the Joint Commission on Accreditation of Health Care Organizations on either an inpatient or outpatient basis.

5. A residential alcoholism, chemical dependency or drug addiction treatment facility accredited by the Joint Commission on Accreditation of Health Care Organizations or licensed or certified by the state of jurisdiction. In no event shall the term hospital include a skilled nursing facility or any institution or part thereof which is used primarily as a skilled nursing facility, nursing home, rest home or facility for the aged;

(Y) Lifetime—The period of time you or your eligible dependents participate in the plan;

(Z) Medical benefits coverage—Services that are received from providers recognized by the plan and are covered benefits under the plan;

(AA) Medically necessary—Services and/or supplies usually rendered or prescribed for the specific illness or injury;

(BB) Nurse—A registered nurse (RN), licensed practical nurse (LPN) or licensed vocational nurse (LVN). Nurse shall also include an employee of an institution operated principally for treating sick and injured persons through spiritual means which meets the requirements of a hospital as defined in this rule;

(CC) Open enrollment period—A period designated by the plan during which subscribers may enroll, switch, or change their level of coverage in any of the available health care options with the new coverage becoming effective as of the beginning of the new plan year;

(DD) Out-of-area—Applies to claims of members living in specified zip code areas where the number of available providers does not meet established criteria;

(EE) Out-of-network—Providers that do not participate in the member's health plan;

(FF) Participant—Any employee or dependent accepted for membership in the plan;

(GG) Physically or mentally disabled—The inability of a person to be self-sufficient as the result of a condition diagnosed by a physician as a continuing condition;

(HH) Physician/Doctor—A licensed practitioner of the healing arts, acting within the scope of his/her practice as licensed under section 334.021, RSMo;

(II) Plan—The program of health care benefits established by the trustees of the Missouri Consolidated Health Care Plan as authorized by state law;

(JJ) Plan administrator—The trustees of the Missouri Consolidated Health Care Plan;

(KK) Plan document—The statement of the terms and conditions of the plan as adopted by the plan administrator in the "2005 Missouri Consolidated Health Care Plan Public Entity Employee Member Handbook" with respect to dental and vision coverage and incorporated by reference in this rule, as published in August 2004 by the Missouri Consolidated Health Care Plan, PO Box 104355, Jefferson City, MO 65110. This rule does not incorporate any subsequent amendments or additions. Note: The plan documents for medical plans are provided by the fully-insured contractors of such plans, and such plan documents may be obtained by contacting those contractors directly. The names, addresses, and phone numbers of the fully-insured contractors may be found in the "2005 Missouri Consolidated Health Care Plan Public Entity Employee Member Handbook";

(LL) Plan year—Same as benefit year;

(MM) Point-of-service (POS)—A plan which provides a wide range of comprehensive health care services, like an HMO, if in-network providers are utilized, and like a PPO plan, if non-network providers are utilized;

(NN) Pre-admission testing—X-rays and laboratory tests conducted prior to a hospital admission which are necessary for the admission;

(OO) Preferred provider organization (PPO)—An arrangement with providers where discounted rates are given to members of the plan who, in turn, are offered a financial incentive to use these providers;

(PP) Prior plan—The terms and conditions of a plan in effect for the period preceding coverage in the MCHCP;

(QQ) Provider—Hospitals, physicians, chiropractors, medical agencies, or other specialists who provide medical care within the scope of his/her practice and are recognized under the provisions and administrative guidelines of the plan. Provider also includes a qualified practitioner of an organization which is generally recognized for

health insurance reimbursement purposes and whose principles and practices of spiritual healing are well established and recognized;

(RR) Public entity—A state-sponsored institution of higher learning, political subdivision or governmental entity or instrumentality that has elected to join the plan and has been accepted by the board;

(SS) Review agency—A company responsible for administration of clinical management programs;

(TT) Second opinion program—A consultation and/or exam with a physician qualified to perform the procedure who is not affiliated with the attending physician/surgeon, for the purpose of evaluating the medical necessity and advisability of undergoing a surgical procedure or receiving a service;

(UU) Skilled nursing facility (SNF)—An institution which meets fully each of the following requirements:

1. It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury: room, board and twenty-four (24) hour-a-day nursing service by one (1) or more professional nurses and nursing personnel as are needed to provide adequate medical care;

2. It provides the services under the supervision of a proprietor or employee who is a physician or registered nurse; and it maintains adequate medical records and has available the services of a physician under an established agreement, if not supervised by a physician or registered nurse; and

3. A skilled nursing facility shall be deemed to include institutions meeting the criteria in subsection (1)(UU) of this rule which are established for the treatment of sick and injured persons through spiritual means and are operated under the authority of organizations which are recognized under Medicare (Title I of Public Law 89-97);

(VV) State—Missouri;

(WW) Subscriber—The employee or member who elects coverage under the plan;

(XX) Survivor—A member who meets the requirements of 22 CSR 10-3.020(6)(A);

(YY) Unemancipated child(ren)—A natural child(ren), a legally adopted child(ren) or a child(ren) placed for adoption, and a dependent disabled child(ren) over twenty-three (23) years of age (during initial eligibility period only and appropriate documentation may be required by the plan), and the following:

1. Stepchild(ren);

2. Foster child(ren) for whom the employee is responsible for health care;

3. Grandchild(ren) for whom the employee has legal custody and is responsible for providing health care;

4. Other child(ren) for whom the employee is legal custodian subject to specific approval by the plan administrator. Except for a disabled child(ren) as described in subsection (1)(GG) of this rule, an unemancipated child(ren) is eligible from birth to the end of the month in which s/he is emancipated, as defined here, or attains age twenty-three (23) (twenty-five (25) if attending school full-time and the public entity joining the plan had immediate previous coverage allowing this provision) (see 22 CSR 10-3.020(4)(D)2. for continuing coverage on a handicapped child(ren) beyond age twenty-three (23)); and

5. Stepchild(ren) who are not domiciled with the employee, provided the natural parent who is legally responsible for providing coverage is also covered as a dependent under the plan;

(ZZ) Usual, customary, and reasonable charge—

1. Usual—The fee a physician most frequently charges the majority of his/her patients for the same or similar services;

2. Customary—The range of fees charged in a geographic area by physicians of comparable skills and qualifications for the same performance of similar service;

3. Reasonable—The flexibility to take into account any unusual clinical circumstances involved in performing a particular service; and

4. A formula is used to determine the customary maximum. The customary maximum is the usual charge submitted by ninety percent (90%) of the doctors for ninety percent (90%) of the procedures reported; and

(AAA) Vested subscriber—A member who meets the requirements of 22 CSR 10-3.020(6)(B).

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Original rule filed Dec. 20, 2004.

PUBLIC COST: The fiscal impact of this proposed rule is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RULE

22 CSR 10-3.020 Subscriber Agreement and General Membership Provisions

PURPOSE: This rule establishes the policy of the board of trustees in regard to the employee's subscriber agreement and membership period for participation in the Missouri Consolidated Health Care Plan.

(1) The participant's initial application, any subsequently accepted modifications to such application, and the plan document as adopted by the board along with duly executed amendments shall comprise the subscriber agreement between the participant and the Missouri Consolidated Health Care Plan (MCHCP). Any associated administrative guidelines interpret the subscriber agreement for the benefit of members and administrators but are not part of the subscriber agreement.

(A) By applying for coverage under the MCHCP a participant agrees that—

1. The employer may deduct the cost of the premium for the employee's plan from the employee's paychecks; and

2. Individual and family deductibles, if appropriate, will be applied. Deductibles previously paid to meet the requirements of the prior plan may be credited for those joining one of the preferred provider organization (PPO) options. Appropriate proof of said deductibles will be required.

(2) The participation period shall begin on the participant's effective date in the plan. Participation shall continue until this plan or coverage in this rule is terminated for any reason. However, transfer from the prior plan to this plan will be automatic upon the effective date of this plan.

(3) The effective date of participation shall be determined, subject to the effective date provision in subsection (3)(C), as follows:

(A) Employee Participation.

1. If application by an employee is made on or before the date of eligibility, participation shall become effective on such date of eligibility;

2. If application by an employee is made within thirty-one (31) days after the date of eligibility, participation may become effective on the date of eligibility or the first day of the calendar month coinciding with or following the date of application, except that participation shall be retroactive to the beginning of the month for employees rehired during the month following the month participation would have terminated; and

3. Not limiting or excluding any of the other provisions, if application is not made within thirty-one (31) days of the employee's date of eligibility, they may apply for coverage only if a life event occurs. Life events include: marriage, birth, adoption, death, divorce, legal separation, job loss or failure to elect continuation of coverage. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee's responsibility to notify the plan administrator of the life event;

(B) Dependent Coverage. Dependent participation cannot precede the subscriber's participation. Application for participants must be made in accordance with the following provisions. For family coverage, once a subscriber is participating with respect to dependents, newly acquired dependents are automatically covered on their effective dates as long as the plan administrator is notified within thirty-one (31) days of the person becoming a dependent. First eligible dependents must be added within thirty-one (31) days of such qualifying event. The employee is required to notify the plan administrator on the appropriate form of the dependent's name, date of birth, eligibility date and Social Security number, if available. Claims will not be processed until the required information is provided.

1. If an employee makes concurrent application for dependent participation on or before the date of eligibility or within thirty-one (31) days thereafter, participation for dependent will become effective on the date the employee's participation becomes effective;

2. When an employee participating in the plan first becomes eligible with respect to a dependent child(ren), coverage may become effective on the eligibility date or the first day of the month coinciding with or following the date of eligibility if application is made within thirty-one (31) days of the date of eligibility and provided any required contribution for the period is made;

3. Unless required under federal guidelines—

A. An emancipated dependent who regains his/her dependent status is immediately eligible for coverage if an application is submitted within thirty-one (31) days of regaining dependent status; and

B. An eligible dependent that is covered under a spouse's health plan who loses eligibility under the criteria stipulated for dependent status under the spouse's health plan is not eligible for coverage until the next open enrollment period. (Note: Subparagraphs (3)(B)3.A. and B. do not include dependents of retirees or long-term disability members covered under the plan); and

4. Survivors, retirees, vested subscribers and long-term disability subscribers may only add dependents to their coverage when the dependent is first eligible for coverage;

(C) Effective Date Proviso.

1. In any instance when the employee is not actively working full-time on the date participation would otherwise have become effective, participation shall not become effective until the date the employee returns to full-time active work. However, this provision shall not apply for public entities (or any individual who is a member of that public entity) when the MCHCP is replacing coverage for that public entity;

(D) Application for dependent coverage may be made at other times of the year when the spouse's, ex-spouse's (who is the natural parent providing coverage), or legal guardian's: 1) employment is terminated or is no longer eligible for coverage under his/her employer's plan, or 2) employer-sponsored medical plan is terminated. With respect to dependent child(ren) coverage, application may also be made at other times of the year when the member receives a court order stating s/he is responsible for providing medical coverage for the dependent child(ren) or when the dependent loses Medicaid coverage. Dependents added under any of these exceptions must supply verification from the previous insurance carrier or the member's employer that they have lost coverage and the effective date of termination. Coverage must also be requested within sixty (60) days from the termination date of the previous coverage. Application must be made within sixty (60) days of the court order. (Note: This section does not include dependents of retirees, survivors, vested subscribers, or long-term disability subscribers covered under the plan); and

(E) When an employee experiences applicable life events, eligibility will be administered according to Health Insurance Portability and Accountability Act (HIPAA) guidelines.

(4) Termination of participation shall occur on the last day of the calendar month coinciding with or following the happening of any of the following events, whichever shall occur first:

(A) Written request by the employee;

(B) Failure to make any required contribution toward the cost of coverage;

(C) Entry into the armed forces of any country. With respect to an employee, membership in the National Guard or Reserves with or without two (2) consecutive full weeks of active training each year shall not be considered as entry into the armed forces; or

(D) Termination of Eligibility for Participation.

1. With respect to employees, termination of participation shall occur upon termination of employment in a position covered by the MCHCP, except as specified in sections (5) and (6).

2. With respect to dependents, termination of participation shall occur upon ceasing to be a dependent as defined in this rule with the following exception: unemancipated mentally retarded and/or physically handicapped children will continue to be eligible beyond age twenty-three (23) during the continuance of a permanent disability provided documentation satisfactory to the plan administrator is furnished by a physician prior to the dependent's twenty-third birthday, and as requested at the discretion of the plan administrator.

3. Termination of employee's participation shall terminate the participation of dependents, except as specified in section (6).

(5) Termination of participation shall occur immediately upon discontinuance of the plan subject to the plan termination provision specified in 22 CSR 10-2.080(1).

(6) Continuation of Coverage.

(A) Dependents. Termination of an active employee's participation by reason of death shall not terminate participation with respect to the surviving spouse and/or dependent children if—

1. The active employee was vested and eligible for a future retirement benefit; or

2. Your eligible dependents meet one (1) of the following conditions:

A. They have had coverage through MCHCP since the effective date of the last open enrollment period;

B. They have had other health insurance for the six (6) months immediately prior to your death—proof of insurance is required; or

C. They have had coverage through MCHCP since they were first eligible.

(B) Employee Eligible for Retirement Benefits. Any employee who, at the time of termination of employment, met the following—

1. Eligibility Criteria:

A. Coverage through MCHCP since the effective date of the last open enrollment period;

B. Other health insurance for the six (6) months immediately prior to the termination of state employment—proof of insurance is required; or

C. Coverage since first eligible;

2. Immediately eligible to receive a monthly retirement benefit from the retirement system of the participating public entity may elect to continue to participate in the plan by paying the cost of plan benefits as determined by the plan administrator. An employee must apply for continued coverage within thirty-one (31) days of the first day of the month following the date of retirement. An employee, continuing coverage under this provision, may also continue coverage for eligible dependents.

A. If a member participates in the MCHCP as a vested member, his/her dependents may also participate if they meet one (1) of the following criteria:

(I) They have had coverage through MCHCP since the effective date of the last open enrollment period;

(II) They have had other health insurance for the six (6) months immediately prior to state employment termination—proof of insurance is required; or

(III) They have had coverage since they were first eligible;

3. In the case of the death of a retiree who was maintaining dependent coverage under this provision, the dependent of the deceased retiree may continue his/her participation under the plan. However, retirees, survivors, vested subscribers and long-term disability subscribers and their dependents are not later eligible if they discontinue their coverage at some future time, except as noted in (7)(B)4.; and

4. A vested or retired member may elect to suspend their coverage upon entry into the armed forces of any country by submitting a copy of their activation papers within thirty-one (31) days of their activation date. Coverage will be suspended the first of the month following the month of activation. Coverage may be reinstated at the same level upon discharge by submitting a copy of their separation papers and a completed enrollment form within thirty-one (31) days of their separation date. Coverage will be reinstated as of the first of the month following the month of separation.

(C) Coverage at Termination. A former employee may participate in the plan if s/he terminates employment before retirement provided s/he is a vested employee. This means s/he will be eligible for a benefit from the retirement system of the participating public entity when s/he reaches retirement age. The election to participate must be made within thirty-one (31) days from the last day of the month in which employment terminated. The member must pay the full cost of coverage. However, s/he will not later be eligible if s/he discontinues coverage at some future time.

(D) Leave of Absence. An employee on approved leave of absence may elect to retain eligibility to participate in the plan by paying the required contributions. The employing department must officially notify the plan administrator of the leave of absence and any extension of the leave of absence by submitting the required form. Any employee on an approved leave of absence who was a member of the Missouri Consolidated Health Care Plan when the approved leave began, but who subsequently terminated participation in the Missouri Consolidated Health Care Plan while on leave, may recommence his/her coverage in the plan at the same level (employee only, or employee and dependents) upon returning to employment directly from the leave, but they will be subject to preexisting limitations, when applicable. Preexisting limitations under this provision will not apply to health maintenance organization (HMO) or point-of-service (POS) members. However, eligibility is terminated for those members receiving a military leave of absence, as specified in subsection (5)(C). Coverage may be reinstated upon return from military leave without proof of insurability or preexisting conditions. However, the former member must complete an enrollment form. Coverage under this provision is effective on the first of the month coinciding with or following the employee's return to work. Coverage will be continuous if the employee returns to work in the subsequent month following the initial leave date and timely requests reinstatement of coverage.

(E) Layoff. An employee on layoff status may elect to retain eligibility to participate in the plan by paying the required contribution for a maximum of twenty-four (24) months with recertification of status at least every twelve (12) months by the employing department. Eligibility will terminate if the employee becomes eligible for health benefits as an employee of another employer. If participation terminates and the employee is recalled to service, eligibility will be as a new employee.

(F) Workers' Compensation. Any person who is receiving, or is entitled to receive, Workers' Compensation benefits as a result of an injury or accident sustained in employment and who was a member of the plan at the time of becoming disabled may continue his/her coverage in the plan at the same level of participation (employee only or employee and dependents) by paying the required contributions, if the disability occurred in the employment through which the employee qualifies for membership in the plan. Any person receiving, or entitled to receive, Workers' Compensation benefits who was a member of the plan at the time of becoming disabled as a result of an injury or accident sustained in employment through which the person qualified for membership in the plan, but who subsequently terminated participation in the plan, may recommence his/her coverage in the plan at the same level (employee only, or employee and dependents) upon returning to employment, without proving insurability.

(G) Reinstatement After Dismissal. If an employee is approved to return to work after being terminated as a result of legal or administrative action available as a recourse through his/her employer, s/he will be allowed to reinstate his/her medical benefit retroactively to the date of dismissal. If the employee is reinstated with back pay, s/he will be responsible for paying any contribution normally made for either his/her coverage or his/her covered dependents. No preexisting condition limitation will apply. If the employee is reinstated without back pay, s/he will be considered to have been on a leave of absence. Consequently, the employee will be responsible for making any required contribution toward the cost of his/her medical benefits. If the employee does not purchase coverage for the period between termination and reinstatement, s/he may regain the same level of coverage s/he had prior to termination. If the employee participates in a PPO plan, the preexisting condition limitation will apply if coverage lapsed more than sixty-three (63) days. This does not apply if the employee participates in an HMO or POS.

(7) Federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

(A) In accordance with the COBRA, eligible employees and their dependents may continue their medical coverage after the employee's termination date.

1. Employees terminating for reasons other than gross misconduct may continue coverage for themselves and their covered dependents for eighteen (18) months at their own expense.

2. A surviving spouse and dependents, not normally eligible for continued coverage, may elect coverage for up to thirty-six (36) months at their own expense.

3. A divorced spouse may continue coverage at his/her own expense for up to thirty-six (36) months if the plan administrator is notified within sixty (60) days from the date coverage would terminate.

4. Dependent spouse and/or child(ren) may continue coverage up to thirty-six (36) months if the covered employee retires and the dependent spouse/child(ren) has not been covered by the plan for two (2) years.

5. Children who would no longer qualify as dependents may continue coverage for up to thirty-six (36) months at their (or their parent's/guardian's) expense if the plan administrator is notified within sixty (60) days of the loss of the dependent's eligibility.

6. Employees who are disabled at termination or become disabled during the first sixty (60) days of coverage may continue coverage for up to twenty-nine (29) months.

7. Premiums for continued coverage will be one hundred two percent (102%) of the health plan rate, one hundred fifty percent (150%) if disabled. Once coverage is terminated under the COBRA provision it cannot be reinstated.

8. All operations under the COBRA provision will be applied in accordance with federal regulations.

(8) Missouri State Law COBRA Wrap-Around Provisions—Missouri law provides that if you lose your group health insurance coverage because of a divorce, legal separation or the death of your spouse you may continue coverage until age sixty-five (65) if: a) You continue and maintain coverage under the thirty-six (36)-month provision of COBRA; and b) You are at least fifty-five (55) years old when your COBRA benefits end. The qualified beneficiary must apply to continue coverage through the wrap-around provisions and will have to pay all of the application premium. MCHCP may charge up to an additional twenty-five percent (25%) of the applicable premium. The above Cancellation of Continuation Coverage also applies to COBRA wrap-around continuation.

(9) Medicare—Participants eligible for Medicare who are not eligible for this plan as their primary plan, shall be eligible for benefits no less than those benefits for participants not eligible for Medicare. For such participants who elect to continue their coverage, benefits of this plan shall be coordinated with Medicare benefits on the then standard coordination of benefits basis to provide up to one hundred percent (100%) reimbursement for covered charges.

(A) If a participant eligible for Medicare who is not eligible for this plan as the primary plan is not covered by Medicare, an estimate of Medicare Part A and/or Part B benefits shall be made and used for coordination or reduction purposes in calculating benefits. Benefits will be calculated on a claim submitted basis so that if, for a given claim, Medicare reimbursement was for more than the benefits provided by this plan without Medicare, the balance will not be considered when calculating subsequent claims; and

(B) If any retired participants or long-term disability recipients, their eligible dependents or surviving dependents eligible for coverage elect not to be continuously covered from the date first eligible, or do not apply for coverage within thirty-one (31) days of their eligibility date, they shall not thereafter be eligible for coverage.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Original rule filed Dec. 20, 2004.

PUBLIC COST: The fiscal impact of this proposed rule is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RULE

22 CSR 10-3.030 Public Entity Membership Agreement and Participation Period

PURPOSE: This rule establishes the policy of the board of trustees in regard to the public entity's membership agreement and participation period with the Missouri Consolidated Health Care Plan.

(1) The application packet, participation agreement and confirmation notice shall comprise the membership agreement between a public entity and the Missouri Consolidated Health Care Plan (MCHCP).

(A) By applying for coverage under the MCHCP a public entity agrees that—

1. The MCHCP will be the only health care offering made to its eligible members;

2. If the public entity participated in the MCHCP during calendar year 2004 and continues to participate each year subsequent to calendar year 2004, that public entity shall only be required to contribute twenty-five dollars ($25) per month towards the employee only premium for each active employee's premium for the plan(s) offered through MCHCP during calendar years 2005 and 2006;

3. If the public entity did not participate in the MCHCP during calendar year 2004, that public entity shall contribute at least fifty percent (50%) of the lowest cost employee only premium per month toward each active employee's premium for the plan(s) offered through MCHCP;

4. Beginning January 1, 2007, all public entities shall contribute at least fifty percent (50%) of the lowest cost employee only premium per month toward each active employee's premium for the plan(s) offered through MCHCP;

5. For public entities with less than twenty-five (25) employees, the public entity shall only offer one (1) plan choice to its employees. For public entities with twenty-five (25) or more employees, the public entity may offer more than one (1) plan choice provided by MCHCP.

6. For public entities with more than a total of three (3) employees, at least seventy-five percent (75%) of all eligible employees must join the MCHCP. For public entities with three (3) or fewer employees, a minimum of one (1) employee must join the MCHCP. For public entities with three (3) or fewer employees who fail to have one (1) employee participating in the MCHCP, MCHCP will allow the public entity up to twelve (12) months in which to attempt to meet the participation requirements before terminating for failure to meet the participation requirements. Such a termination for those public entities with three (3) or fewer employees will occur retroactively to the date such participation requirement failed to be met;

7. Individual and family deductibles, if applicable, will be applied. Deductibles previously paid to meet the requirements of the terminating plan may be credited for those joining one of the PPO options. Appropriate proof of said deductibles will be required;

8. An eligible employee is one that is not covered by another group sponsored plan;

9. Any individual eligible as an employee may be covered as either an employee or dependent, but not both. Employees enrolled as dependents will not be considered as eligible employees in consideration of section (6); and

10. A public entity may apply a probationary period, not to exceed applicable federal guidelines, before benefits become effective.

(B) Effective January 1, 2001, in order to provide retiree coverage, any participating member agency joining MCHCP must have one of the criteria listed below. If neither of these scenarios is applicable and no retirement plan exists, no "retirees" would exist, so there would be no retiree eligibility.

1. An established retirement plan with contributions shared by both the employee and the employer (or made by the employer only) with an established minimum vesting period. The employer must offer coverage to retirees who have met this minimum vesting period requirement.

2. An employer-sponsored (but no contribution made by employer) retirement plan in which the employee is currently participating or from which the employee is eligible to receive a benefit. In this case, in order to be considered an eligible retiree, the prospective member must have met a vesting criterion equal to Missouri State Employees' Retirement System (MOSERS). If this criterion was not met, the employer may not offer coverage to that person as a retiree.

(2) The public entity's participation period shall begin on the date specified in the participation agreement. Participation shall continue until the end of the participation agreement is reached or immediately upon discontinuance of the plan subject to the plan termination provision specified in 22 CSR 10-3.080(1).

(3) The voluntariness of the public entity's failure to meet participation levels is to be determined by MCHCP. Examples of non-voluntary failure to meet participation levels include: 1) a public entity falls below the required participation level due to employment termination(s); and 2) a public entity falls below the required participation level, but the public entity can prove that all eligible employees who failed to take the coverage have other group coverage not offered through the public entity or are Medicare eligible.

(4) Total premium costs for various classes of employee participation based on employment status, eligibility for Medicare and for various classifications of dependent participation are established by the plan administrator.

(5) Underwriting guidelines are set by the plan administrator.

(6) The contribution by the employee shall be determined, within the underwriting guidelines set by the plan administrator, by the appropriate administrative unit for the public entity.

(7) Refunds of overpayments are limited to the amount overpaid during the twelve (12)-month period ending at the end of the month preceding the month during which notice of overpayment is received.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Original rule filed Dec. 20, 2004.

PUBLIC COST: The fiscal impact of this proposed rule is estimated to be nine thousand dollars ($9,000) annually in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rule will cost private entities less than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC COST

I. RULE NUMBER

Title: 22 – Missouri Consolidated Health Care Plan

Division: Division 10

Chapter: Chapter 3

Type of Rulemaking: Proposed Rule

Rule Number and Name: 22 CSR 10-3.030 Public Entity Membership Agreement and Participation Period

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
5	Public entities not enrolled with the MCHCP in calendar year 2004 but that join the MCHCP for calendar years 2005 and beyond	$9,000 annual

III. WORKSHEET

The minimum contribution amounts paid by public entities were modified in order to make MCHCP's plans more attractive and less costly to public entity members.

IV. ASSUMPTIONS

1. Based on marketing projections, estimate that fifty (50) additional public entities will join the MCHCP that were not enrolled during calendar year 2004;
2. Based on past contribution levels of participating entities, estimate that ten percent (10%) of those fifty (50) public entities would have paid less than fifty percent (50%) of employee only premium if given a choice;
3. Ten percent (10%) of those fifty (50) public entities equals five (5) public entities estimated to be affected by this rule;
4. Of those previously enrolled entities that paid less than fifty percent (50%) of the employee only premium, the average entity paid sixteen percent (16%) of the employee only premium. Thus, the average additional cost to the entities would be thirty-four percent (34%) of the employee only premium;
5. Average premium for employee only coverage for public entities for calendar year 2005 equals four hundred ten dollars ($410) per month; and
6. Estimated premium amounts for calendar year 2006 based on thirteen percent (13%) medical trend and sixteen percent (16%) prescription trend; and
7. Actual premium costs could vary based upon actual utilization of services and risk of groups joining the plan.

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RULE

22 CSR 10-3.070 Coordination of Benefits

PURPOSE: This rule establishes the policy of the board of trustees in regard to coordination of benefits in the Missouri Consolidated Health Care Plan.

(1) If a participant is also covered under any other plan (as defined here) and is entitled to benefits or other services for which benefits are payable under this plan, the benefits under this plan will be adjusted as shown in this rule.

(2) As used in this rule—

(A) Plan means a plan listed in the following which provides medical, vision, dental or other health benefits or services:

1. A group or blanket plan on an insured basis;
2. Other plan which covers people as a group;
3. A self-insured or non-insured plan or other plan which is arranged through an employer, trustee or union;
4. A prepayment group plan which provides medical, vision, dental or health service;
5. Government plans, including Medicare;
6. Auto insurance when permitted by the laws of the state of jurisdiction; and
7. Single- or family-subscribed plans issued under a group- or blanket-type plan;

(B) The definition of plan shall not include:

1. Hospital preferred provider organization (PPO) type plans;
2. Types of plans for students; or
3. Any individual policy or plan;

(C) Each plan, as defined previously, is a separate plan. However, if only a part of the plan reserves the right to adjust its benefits due to other coverage, the portion of the plan which reserves the right and the portion which does not shall be treated as separate plans;

(D) Allowable expense means a necessary, reasonable and customary item of medical, vision, dental or health expense which is covered at least in part under one of the plans. If a plan provides benefits in the form of services, the cash value of such service will be deemed to be the benefit paid. An allowable expense to a secondary plan includes the value or amount of any allowable expense which was not paid by the primary or first paying plan; and

(E) Benefit determination period means from January 1 of one year through December 31 of the same year.

(3) The benefits under the policy shall be subject to the following:

(A) This provision shall apply in determining the benefit as to a person covered under the policy for a benefit determination period if the sum of paragraphs (3)(A)1. and 2. listed in this rule exceeds the allowable expense incurred by or on behalf of such person during the period—

1. The benefits payable under this plan in the absence of this provision; and
2. The benefits payable under all other plans in the absence of provisions similar to this one;

(B) As to any benefit determination period, the allowable expense under this plan shall be coordinated, except as provided in subsection (3)(C) of this rule, so that the sum of such benefits and all of the benefits paid, payable or furnished which relate to such allowable expense under other plans, shall not exceed the total of allowable expenses incurred by the covered individual. All benefits under other plans shall be taken into account whether or not claim has been made;

(C) If coverage under any other plan is involved, as shown in subsection (3)(B) of this rule—

1. This plan contains a provision coordinating benefits with other plans; and
2. The terms set forth in subsection (2)(D) would require benefits under this plan be figured before benefits under the other plan are figured, the benefits under this plan will be determined as though other plans were not involved;

(D) The basis for establishing the order in which plans determine benefits shall be as follows:

1. Benefits under the plan which cover the person on whom claim is based as an employee shall be determined before the benefits under a plan which cover the person as a dependent; and
2. The primary plan for dependent children will be the plan of the parent whose birthday occurs first in the calendar year. If both parents have the same birthday, the plan of the person who has been covered the longest period of time becomes the primary carrier:

A. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of the plan which covers the child as a dependent of the parent without custody;

B. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody; and

C. In spite of subparagraphs (3)(D)2.A. and B. of this rule, if there is a court decree which would otherwise decide financial duty for the medical, vision, dental or health care expenses for the child, the benefits of a plan which covers the child as a dependent of the parent with such financial duty shall be decided before the benefits of any other plan which covers the child as a dependent; and when paragraphs (3)(D)1. and 2. of this rule do not establish the order of benefit determination, the plan which covers the person for the longer time shall be determined first; and

(E) When this provision operates to reduce the benefits under this plan, each benefit that would have otherwise been paid will be reduced proportionately and this reduced amount shall be charged against the benefit limits of this plan.

(4) When a member has coverage with two (2) group plans, the plan which covers the person for the longer time shall be determined first.

(5) If a member is eligible for Medicare due to a disability, Medicare is the primary plan and this plan is a secondary plan. If a member or dependent is eligible for Medicare due to end stage renal disease, this plan is primary for the first thirty (30) months. Medicare is primary after the first thirty (30) months.

(6) The claims administrator, with the consent of the employee or the employee's spouse when the claim is for a spouse, or the parent or guardian when the claim is for a minor child, may release or obtain any data which is needed to implement this provision.

(7) When payments should have been paid under this plan but were already paid under some other plan, the claims administrator shall have the right to make payment to such other plan of the amount which would satisfy the intent of this provision. This payment shall discharge the liability under this plan.

(8) When payments made under this plan are in excess of the amount required to satisfy the intent of this provision, the claims administrator shall have the right to recover the excess payment from one (1) or more of the following:

(A) Any person to whom, for whom or with respect to whom these payments were made;
(B) Any insurance company; or
(C) Any other organization.

(9) The claims administrator will pay benefits promptly, or, if applicable, within their contractual time frame obligations after submittal of due proof of loss unless the claims administrator provides the claimant a clear, concise statement of a valid reason for further delay which is in no way connected with, or caused by the existence of this provision nor otherwise caused by the claims administrator.

(10) If one of the other plans involved (as defined in coordination of benefits provision) provides benefits on an excess insurance or excess coverage basis, subsections (3)(C) and (D) of this rule shall not apply to the plan and this policy will pay as excess coverage.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Original rule filed Dec. 20, 2004.

PUBLIC COST: The fiscal impact of this proposed rule is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RULE

22 CSR 10-3.075 Review and Appeals Procedure

PURPOSE: This rule establishes the policy of the board of trustees in regard to review and appeals procedures for participation in the Missouri Consolidated Health Care Plan.

(1) When any participant shall suffer any injury or sickness giving rise to claim under these rules, s/he shall have free choice of providers practicing legally in the location in which service is provided to the end that a provider/patient relationship shall be maintained. Reimbursement will be in accordance with the benefit provisions of the type of coverage chosen by the participant.

(2) The plan administrator, agent or claims administrator, upon receipt of a notice of request, shall furnish to the employee the forms as are usually furnished for filing proofs of loss. If the forms are not furnished within thirty (30) days after the giving of such notice, the employee shall be deemed to have complied with the requirement as to proof of loss upon submitting, within the time fixed for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which request is made.

(3) Written proof of claims incurred should be furnished to the claims administrator as soon as reasonably possible. Claims filed more than one (1) year after charges are incurred will not be honored. All claims are reviewed and/or investigated by the claims administrator before they are paid.

(4) In the case of medical benefits, the claims administrator will send written notice of any amount applied toward the deductible as well as any payments made. The claims administrator may also send a request for additional information or material to support the claim, along with reasons why this information is necessary.

(5) All insured members of the Missouri Consolidated Health Care Plan (MCHCP) shall use the claims and administration procedures established by the health maintenance organization (HMO), point-of-service (POS), or preferred provider organization (PPO) health plan contract applicable to the insured member. Only after these procedures have been exhausted may the member appeal directly to the Missouri Consolidated Health Care Plan Board of Trustees to review the decision of the health plan contractor.

(A) Appeals to the board of trustees shall be submitted in writing within forty-five (45) days of receiving the final decision from the member's health care plan, specifically identifying the issue to be resolved and be addressed to:

Attn: Appeal
Board of Trustees
Missouri Consolidated Health Care Plan
PO Box 104355
Jefferson City, MO 65110

(B) The board may utilize a hearing officer, such as the Administrative Hearing Commission, to conduct a fact-finding hearing, and make proposed findings of fact and conclusions of law.

1. The hearing will be scheduled by the MCHCP.

2. The parties to the hearing will be the insured and the applicable health plan.

3. All parties shall be notified in writing of the date, time and location of the hearing.

4. All parties shall have the right to appear at the hearing and submit written or oral evidence. The appealing party shall be responsible for all copy charges incurred by MCHCP in connection with any documentation that must be obtained through the MCHCP. These fees will be reimbursed should the party prevail in his/her appeal. They may cross-examine witnesses. They need not appear and may still offer written evidence. The strict rules of evidence shall not apply.

5. The party appealing to the board shall carry the burden of proof.

6. The independent hearing officer shall propose findings of fact and conclusions of law, along with its recommendation, to the board. Copies of the summary, findings, conclusions and recommendations shall be sent to all parties.

(C) The board may, but is not required to, review the transcript of the hearing. It will review the summary of evidence, the proposed findings of fact and conclusions of law and shall then issue its final decision on the matter.

1. All parties shall be given a written copy of the board's final decision.

2. All parties shall be notified that if they feel aggrieved by the final decision, they shall have the right to seek judicial review of the decision within thirty (30) days of its receipt, as provided in sections 536.100 to 536.140, RSMo.

(D) Administrative decisions made solely by MCHCP may be appealed directly to the board of trustees, by either an insured member or health plan contractor.

1. All the provisions of this rule, where applicable, shall apply to these appeals.

2. The parties to such appeal shall be the appellant and the MCHCP shall be respondent.

3. The appellant, if aggrieved by the final decision of the board, shall have the right of appeal as stated in subsection (5)(C) herein.

4. In reviewing these appeals, the board and/or staff may consider:

A. Newborns—

(I) Notwithstanding any other rule, if a member currently has children coverage under the plan, he/she may enroll his/her newborn retroactively to the date of birth if the request is made within six (6) months of the child's date of birth. If a member does not currently have children coverage under the plan but states that the required information was provided within the thirty-one (31)-day enrollment period, he/she must sign an affidavit stating that their information was provided within the required time period. The affidavit must be notarized and received in the MCHCP office within thirty-one (31) days after the date of notification from the MCHCP; and

(II) Once the MCHCP receives the signed affidavit from the member, coverage for the newborn will be backdated to the date of birth, if the request was made within six (6) months of the child's date of birth. The approval notification will include language that the MCHCP has no contractual authority to require the contractors to pay for claims that are denied due to the retroactive effective date. If an enrollment request is made under either of these two (2) scenarios past six (6) months following a child's date of birth, the information will be forwarded to the MCHCP board for a decision.

B. Credible evidence—Notwithstanding any other rule, the MCHCP may grant an appeal and not hold the member responsible when there is credible evidence that there has been an error or miscommunication, either through the member's payroll/personnel office or the MCHCP, that was no fault of the member.

C. Change of plans due to dependent change of address—A member may change plans outside the open enrollment period if his/her covered dependents move out of state and their current plan cannot provide coverage.

(E) Any member wishing to appeal their enrollment selection completed during the annual open enrollment period must do so in writing to the board of trustees within thirty (30) calendar days of the beginning of the new plan year. The MCHCP will respond within thirty (30) calendar days of the receipt of the appeal.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Original rule filed Dec. 20, 2004.

PUBLIC COST: The fiscal impact of this proposed rule is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 3—Public Entity Membership

PROPOSED RULE

22 CSR 10-3.080 Miscellaneous Provisions

PURPOSE: This rule establishes the policy of the board of trustees in regard to miscellaneous provisions under the Missouri Consolidated Health Care Plan.

(1) Termination of the Plan. Any other provision of this plan to the contrary notwithstanding, no benefit will be paid for charges incurred by a participant or former participant after the termination of this plan.

(2) Facility of Payment. Plan benefits will be paid to the employee if living and capable of giving a valid release for the payment due. If the participant, while living, is physically, mentally or for any other reason incapable of giving a valid release for any payment due, the claims administrator at his/her option, unless and until request is made by the duly appointed guardian, may pay benefits which may become due to any blood relative or relative connected by marriage to the participant, or to any other person or institution appearing to the claims administrator to have assumed responsibility for the affairs of the participant. Any payments made by the claims administrator in good faith pursuant to this provision shall fully discharge the claims administrator to the extent of the payment. Any benefit unpaid at the time of the employee's death will be paid to the employee's estate. If any benefits shall be payable to the estate of the employee, the claims administrator may pay these benefits to any relative by blood or connection by marriage of the employee who is deemed by the claims administrator to be equitably entitled to it. Any payments made by the claims administrator in good faith pursuant to this provision shall fully discharge the claims administrator to the extent of this payment. Subject to any acceptable written direction and assignment by the employee, any benefits provided, at the claims administrator's option, may be paid directly to an eligible provider rendering covered services; but it is not required that the service be rendered by a particular provider.

(3) Confidentiality of Records. The health records of the participants in the plan are confidential and shall not be disclosed to any person, except pursuant to a written request by, or with the prior written consent of, the individual to whom the records pertain, unless disclosure of the records would be to the officers and employees of the plan or claims administrator or his/her legal representatives who have a need for the records in the performance of their duties; or unless disclosure would be for a routine use by the plan or claims administrator for a purpose which is compatible with the purpose for which it was collected; or unless disclosure of the records would be to the commissioner of administration, or his/her legal representative, for the sole purpose of preventing fraudulent or redundant medical claims to either the Missouri Consolidated Health Care Plan, Missouri, or other public entities as an employer or self-insurer of Workers' Compensation for use in the investigation of a Workers' Compensation claim; or unless disclosure of the records is to the participant to whom the record pertains; or unless disclosure of the record is pursuant to the order of a court of competent jurisdiction. The parent of any minor, or the legal guardian of any individual who has been declared to be incompetent due to physical or mental incapacity by a court of competent jurisdiction, may act on behalf of the individual.

(4) Should any provision of this plan conflict with the requirements of federal or state law, including but not limited to the Health Insurance Portability and Accountability Act, Family and Medical Leave Act, the Americans with Disabilities Act or the Older Workers Benefit Protection Act, the plan shall be administered in such a way as to comply with the requirements of law, and will be deemed amended to conform with law.

(5) This document will be kept on file at the principal offices of the plan administrator and may be inspected by a participant during regular business hours. Also, the plan administrator reserves the right

at any time to modify or amend, in whole or in part, any or all provisions of the plan.

AUTHORITY: section 103.059, RSMo 2000. Emergency rule filed Dec. 20, 2004, effective Jan. 1, 2005, expires June 29, 2005. Original rule filed Dec. 20, 2004.

PUBLIC COST: The fiscal impact of this proposed rule is estimated to be less than five hundred dollars ($500) in the aggregate for state agencies or political subdivisions.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Consolidated Health Care Plan, Ron Meyer, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

This section will contain the final text of the rules proposed by agencies. The order of rulemaking is required to contain a citation to the legal authority upon which the order of rulemaking is based; reference to the date and page or pages where the notice of proposed rulemaking was published in the *Missouri Register*; an explanation of any change between the text of the rule as contained in the notice of proposed rulemaking and the text of the rule as finally adopted, together with the reason for any such change; and the full text of any section or subsection of the rule as adopted which has been changed from that contained in the notice of proposed rulemaking. The effective date of the rule shall be not less than thirty (30) days after the date of publication of the revision to the *Code of State Regulations*.

The agency is also required to make a brief summary of the general nature and extent of comments submitted in support of or opposition to the proposed rule and a concise summary of the testimony presented at the hearing, if any, held in connection with the rulemaking, together with a concise summary of the agency's findings with respect to the merits of any such testimony or comments which are opposed in whole or in part to the proposed rule. The ninety (90)-day period during which an agency shall file its Order of Rulemaking for publication in the *Missouri Register* begins either: 1) after the hearing on the Proposed Rulemaking is held; or 2) at the end of the time for submission of comments to the agency. During this period, the agency shall file with the secretary of state the order of rulemaking, either putting the proposed rule into effect, with or without further changes, or withdrawing the proposed rule.

Title 2—DEPARTMENT OF AGRICULTURE
Division 70—Plant Industries
Chapter 40—Missouri Treated Timber Products Law Rules

ORDER OF RULEMAKING

By the authority vested in the Department of Agriculture under section 280.050, RSMo 2000, the director amends a rule as follows:

2 CSR 70-40.015 Standards for Treated Timber **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 1, 2004 (29 MoReg 1439). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 2—DEPARTMENT OF AGRICULTURE
Division 70—Plant Industries
Chapter 40—Missouri Treated Timber Products Law Rules

ORDER OF RULEMAKING

By the authority vested in the Department of Agriculture under section 280.050, RSMo 2000, the director amends a rule as follows:

2 CSR 70-40.025 Standards for Inspection, Sampling and Analysis **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 1, 2004 (29 MoReg 1439–1440). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 6—Wildlife Code: Sport Fishing: Seasons, Methods, Limits

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-6.505 Black Bass **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1793). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 6—Wildlife Code: Sport Fishing: Seasons, Methods, Limits

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission adopts a rule as follows:

3 CSR 10-6.511 is adopted.

This rule establishes fishing seasons and limits and is excepted by section 536.021, RSMo from the requirement for filing as a proposed amendment.

The Department of Conservation adopted 3 CSR 10-6.511 by establishing seasons and limits for an experimental hand fishing season.

3 CSR 10-6.511 Experimental Catfish Hand Fishing Season, Methods, Limits

PURPOSE: This rule establishes an experimental hand fishing season, dates and limits.

(1) An experimental season is established for harvest of catfish by hand fishing methods in designated waters of the state.

(2) Permits Required: A Hand Fishing Permit is required in addition to the prescribed fishing permit, or evidence of exemption, to take or attempt to take catfish by hand. Applications for the Hand Fishing Permit are available from the department. Cost: $7.00.

(3) Daily Limit: Five (5) channel, blue or flathead catfish, in the aggregate, from:

(A) The Fabius River system from the mouth to the Highway 61 bridges and the South Fabius River in Marion County from the Highway 61 bridge upstream to Dunn Ford Access.

(B) The Mississippi River from the mouth of the Fabius River upstream to the mouth of the Des Moines River.

(C) That part of the St. Francis River which forms the boundary between the states of Arkansas and Missouri.

(4) Hand Fishing Methods: Feet and bare hands may be used without the aid of hooks or other man-made devices. Catfish may be taken by this method only from natural objects or natural cavities. Catfish may not be taken by hand fishing from any man-made object except those related to bona fide construction such as bridges, docks, boat ramps and rock riprap. No part of any object may be disturbed or altered to facilitate harvest of catfish. Hand fishers may not possess fishing equipment, except a stringer, while on designated hand fishing waters or adjacent banks.

(5) Season: From sunrise to sunset, June 1 through July 15.

(6) Length Limits: All flathead and blue catfish less than twenty-two inches (22") total length must be returned to the water unharmed immediately after being caught. There is no length limit on channel catfish taken in accordance with this rule.

(7) Reporting: Within ten (10) days following the close of the season, hand fishers shall submit a complete report on a form furnished by the department, showing the dates and waters fished, length, weight, species and sex of catfish taken and other biological data or a negative report if no fish were taken. Failure to submit an accurate and complete annual report shall be sufficient cause for the department to deny renewal of the permit for the following year.

SUMMARY OF PUBLIC COMMENT: Seasons and limits are excepted from the requirement of filing as a proposed amendment under section 536.021, RSMo.

Original rule filed December 21, 2004, effective **January 15, 2005**.

PUBLIC COST: The public cost for this order of rulemaking is estimated to be one hundred twenty-six thousand dollars ($126,000) for Fiscal Year 2005, with the cost recurring annually. The five (5) year aggregate is estimated to be six hundred thirty thousand dollars ($630,000).

FISCAL NOTE
PRIVATE ENTITY COST

I. RULE NUMBER

Title: 3 - Department of Conservation
Division: 10 Conservation Commission
Chapter: 6
Type of Rulemaking: Order of Rulemaking
Rule Number and Name: 3 CSR 10-6.511 Experimental Catfish Hand Fishing Season, Methods, Limits.

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
18,000 fishing permit holders		$630,000

III. WORKSHEET

An estimated 18,000 anglers may choose to buy this permit, which confers an additional privilege above the normal fishing permit. Total cost over the 5 year life is calculated as 18,000 anglers X $7 per permit year X 5 years.

IV. ASSUMPTIONS

The estimated number of anglers in the calculation above is based on responses to a survey asking Missouri catfish anglers how likely they would be to hand fish if it were legal.

Based on Permit Year (March 1 through last day of February next following) NOT fiscal year.

Based on an average five-year life cost. All permit fees are reviewed annually and adjustments made as needed–normally within five years–to remain competitive with other states.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 7—Wildlife Code: Hunting: Seasons, Methods, Limits

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-7.430 Pheasants: Seasons, Limits **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1793–1794). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 7—Wildlife Code: Hunting: Seasons, Methods, Limits

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission adopts a rule as follows:

3 CSR 10-7.438 Deer: Regulations for Department Areas **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1794). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 7—Wildlife Code: Hunting: Seasons, Methods, Limits

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-7.455 is amended.

This amendment establishes hunting seasons and limits and is excepted by section 536.021, RSMo from the requirement for filing as a proposed amendment.

The Department of Conservation amended 3 CSR 10-7.455 by establishing seasons and limits for turkey hunting season during the 2005 seasons.

3 CSR 10-7.455 Turkeys: Seasons, Methods, Limits

PURPOSE: This amendment establishes season dates and bag limits for turkey hunting for the 2005 seasons.

(1) Turkeys may be pursued, taken, killed, possessed or transported only as permitted in this rule.

(B) Fall Firearms Season. Fall season annually will be October 1 through October 31. A person possessing the prescribed turkey hunting permit may take two (2) turkeys of either sex during the season; except that a person at least six (6) but not older than fifteen (15) years of age who possesses a Youth Deer and Turkey Hunting Permit may take only one (1) turkey of either sex during the season. Turkeys may be taken only by shotgun with shot no larger than No. 4 or longbow; without the use of dogs, bait, recorded calls or live decoys; from one-half (1/2) hour before sunrise to sunset in all counties except: Dunklin, McDonald, Mississippi, New Madrid, Newton, Pemiscot and Scott. Possession of shotshells loaded with shot larger than No. 4 is prohibited while hunting turkeys. A person, while in the act of pursuing or hunting turkey on a fall firearms permit, shall not have both a firearm and longbow on his/her person.

(C) Fall Archery Season. A person possessing the prescribed archer's hunting permit may take two (2) turkeys of either sex from September 15 through January 15, excluding the dates of the November portion of the firearms deer season. Turkeys may be taken only by longbow; without the use of dogs, bait, recorded calls or live decoys; from one-half (1/2) hour before sunrise to one-half (1/2) hour after sunset. An archer, while in the act of pursuing or hunting turkey on an archer's permit, shall not have a firearm on his/her person.

(D) Youth Spring Season. The two (2)-day youth spring season will begin annually on the Saturday nine (9) days prior to the Monday opening of the spring season, except that when the youth season would overlap with Easter weekend the season will open on the Saturday prior to Easter weekend. A Missouri resident possessing a Youth Deer and Turkey Hunting Permit or the prescribed turkey hunting permit and who is at least six (6) but not older than fifteen (15) years of age on the opening day of the youth spring season may take only one (1) male turkey or turkey with visible beard during the youth spring season. A turkey harvested during the youth spring season will count towards an individual's spring season bag limit; individuals hunting under the prescribed turkey hunting permit may not harvest a second bird during the first week of the spring season. Turkeys may be taken only by shotgun with shot no larger than No. 4, or longbow, without the use of dogs, bait, recorded calls or live decoys, from one-half (1/2) hour before sunrise to 1:00 p.m. Central Daylight Time (CDT). Possession of shotshells loaded with shot larger than No. 4 is prohibited while hunting turkeys.

SUMMARY OF PUBLIC COMMENT: Seasons and limits are excepted from the requirement of filing as a proposed amendment under section 536.021, RSMo.

This amendment filed December 21, 2004, effective **January 15, 2005**.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 9—Wildlife Code: Confined Wildlife: Privileges, Permits, Standards

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-9.110 General Prohibition; Applications **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1794–1795). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 11—Wildlife Code: Special Regulations for Department Areas

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-11.180 Hunting, General Provisions and Seasons **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1795–1797). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 11—Wildlife Code: Special Regulations for Department Areas

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-11.182 Deer Hunting **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1797–1799). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 11—Wildlife Code: Special Regulations for Department Areas

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission rescinds a rule as follows:

3 CSR 10-11.183 Managed Deer Hunts **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1799). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 12—Wildlife Code: Special Regulations for Areas Owned by Other Entities

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-12.110 Use of Boats and Motors **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1799–1800). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 12—Wildlife Code: Special Regulations for Areas Owned by Other Entities

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-12.115 Bullfrogs and Green Frogs **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1800). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 12—Wildlife Code: Special Regulations for Areas Owned by Other Entities

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-12.125 Hunting and Trapping **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1800–1801). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 12—Wildlife Code: Special Regulations for Areas Owned by Other Entities

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-12.140 Fishing, Daily and Possession Limits **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1801–1802). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 12—Wildlife Code: Special Regulations for Areas Owned by Other Entities

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-12.145 Fishing, Length Limits **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1803). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 20—Wildlife Code: Definitions

ORDER OF RULEMAKING

By the authority vested in the Conservation Commission under sections 40 and 45 of Art. IV, Mo. Const., the commission amends a rule as follows:

3 CSR 10-20.805 Definitions **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 15, 2004 (29 MoReg 1803–1804). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 9—DEPARTMENT OF MENTAL HEALTH
Division 10—Director, Department of Mental Health
Chapter 31—Reimbursement for Services

ORDER OF RULEMAKING

By the authority vested in the Department of Mental Health under sections 630.050 and 630.655, RSMo Supp. 2003, the department adopts a rule as follows:

9 CSR 10-31.014 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1544–1546). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations.*

SUMMARY OF COMMENTS: The department received comments on the proposed rule from nine (9) persons.

COMMENT: Two (2) persons commenting on 9 CSR 10-31.014 stated that the proposed rule was fair and appropriate and had no recommendations.
RESPONSE: The department agrees.

COMMENT: One (1) person commenting on 9 CSR 10-31.014 suggested that a standard application form with instructions be made available to consumers.
RESPONSE: The department agrees that providing a form would be helpful as a suggested guideline only, but does not consider it necessary to incorporate a standardized form into the rule. The department has not revised the proposed rule in response to this comment.

COMMENT: One (1) person commenting on 9 CSR 10-31.014 suggested that the department should adopt procedures to assure families are not overly burdened by inconsistent handling of the waiver process by various providers.
RESPONSE: The department agrees that minimal burden on the consumer is desirable and believes that sending all requests to the director's office will allow for consistency while retaining flexibility. The department has not revised the proposed rule in response to this comment.

COMMENT: Two (2) persons commenting on 9 CSR 10-31.014(1)(B) stated that the proposed rule is unclear as to how it affects children in long-term placement with the Division of Mental Retardation and Developmental Disabilities (MRDD).
RESPONSE: Under the proposed rule, any child served by the department may ask for a waiver. However, because of the criteria established for approval of waivers, the department does not anticipate that many requests will be received on behalf of children in MRDD placement programs. The department has not revised the proposed rule in response to this comment.

COMMENT: One (1) person commenting on 9 CSR 10-31.014(1)(B) asked if the proposed rule would apply to a MRDD Regional Center client exempt from being charged a monthly rate.

RESPONSE: The department agrees that if a child has been exempted from being charged a monthly rate under other provisions of the Standard Means Test, such as for receiving education, special education, or related services, then there would be no need for the parent or custodian to request a waiver under the proposed rule. The department has not revised the proposed rule in response to this comment.

COMMENT: One (1) person commenting on 9 CSR 10-31.014(2) wondered how providers will be reimbursed for any fees that are waived as a result of the proposed rule.
RESPONSE: The proposed rule does not make any changes to the method providers use to invoice for services provided to department clients. Currently, the department reimburses the provider the full contracted service fee for any client who is exempt from the Standard Means Test (SMT). This would include children who receive a waiver of the SMT under the proposed rule. The department has not revised the proposed rule in response to this comment.

COMMENT: One (1) person commenting on 9 CSR 10-31.014(2) expressed concern that some consumers might have to undergo the waiver request process several times within a short period.
RESPONSE: The department has considered the scenarios presented by the commenter and does not agree. Unnecessary repetition of the waiver request process will be avoided because all waiver requests will be handled centrally by the director's office. The department has not revised the proposed rule in response to this comment.

COMMENT: One (1) person commenting on 9 CSR 10-31.014(2) suggested that parents who call for intake services at a psychiatric hospital should be informed of the waiver before the provider makes application of the Standard Means Test, which typically occurs after admission.
RESPONSE: The department agrees that providers should tell concerned parents about the potential waiver at the earliest practicable time. The proposed rule does not preclude information being provided to the consumer prior to admission. The department has not revised the proposed rule in response to this comment.

COMMENT: Two (2) persons commenting on 9 CSR 10-31.014(2)(C) stated that the rule is unclear about how the consumer is to be charged by the provider during the time the waiver request is pending approval or appeal.
RESPONSE AND EXPLANATION OF CHANGE: The department agrees and the proposed rule has been reworded for clarity.

COMMENT: Two (2) persons commenting on 9 CSR 10-31.014(4) asked whether all six (6) items listed in the section were required to be included in the waiver request.
RESPONSE AND EXPLANATION OF CHANGE: The six (6) items are not required. The language of the section has been clarified.

COMMENT: One (1) person commenting on 9 CSR 10-31.014(4)(A) asked what happens when there is no local care team in place.
RESPONSE: The proposed rule states that recommendations can also come from another designated local or regional children's mental health authority, such as the area director of the Division of Comprehensive Psychiatric Services. The department has not revised the proposed rule in response to this comment.

COMMENT: One (1) person commenting on 9 CSR 10-31.014(4)(B) asked what documentation standards applied to substantiation of reports of abuse or neglect.
RESPONSE AND EXPLANATION OF CHANGE: The department reviewed the language and determined that substantiation of reports of abuse or neglect is unnecessary for the purposes of this rule, and the related language has been deleted.

COMMENT: One (1) person commenting on 9 CSR 10-031.014(4)(D) asked for clarification of the documentation requirement for past efforts to obtain needed medical care.
RESPONSE: The proposed rule does not require documentation for past efforts to obtain needed medical care, therefore, no clarification is needed. The department has not revised the proposed rule in response to this comment.

9 CSR 10-31.014 Waiver of Standard Means Test for Children in Need of Mental Health Services

(2) Request for Waiver. At the time of initial application of the Standard Means Test (SMT) for a child in need of mental health services, and at the time of any subsequent reapplication, the provider shall inform the financially responsible person that the SMT may be waived.

(C) For the initial waiver request made on behalf of a child, the provider shall not charge the monthly rate as determined by application of the SMT for services provided during any month in which the request is under review or appeal. This provision applies only to the first waiver request made on behalf of the child.

(4) Consideration of Request. In making the decision to approve, approve with conditions, or deny the request, the designee or designees will consider information presented by the requestor. The requestor may, but is not required to, include information regarding one or more of the items listed below, or any other information in support of their request:

(B) History of the child being in state custody due exclusively to the need for mental health services;

Title 9—DEPARTMENT OF MENTAL HEALTH
Division 45—Division of Mental Retardation and Developmental Disabilities
Chapter 5—Standards for Community-Based Services

ORDER OF RULEMAKING

By the authority vested in the Department of Mental Health under section 630.050, RSMo Supp. 2003, the department rescinds a rule as follows:

9 CSR 45-5.020 Individualized Supported Living Services—Quality Outcome Standards **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 1, 2004 (29 MoReg 1455). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 9—DEPARTMENT OF MENTAL HEALTH
Division 45—Division of Mental Retardation and Developmental Disabilities
Chapter 5—Standards for Community-Based Services

ORDER OF RULEMAKING

By the authority vested in the Department of Mental Health under section 630.050, RSMo Supp. 2003, the department rescinds a rule as follows:

9 CSR 45-5.030 Individualized Supported Living Services—Provider Certification **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 1, 2004 (29 MoReg 1455). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 6—Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

ORDER OF RULEMAKING

By the authority vested in the Missouri Air Conservation Commission under section 643.050, RSMo 2000, the commission amends a rule as follows:

10 CSR 10-6.120 Restriction of Emissions of Lead From Specific Lead Smelter-Refinery Installations **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on August 2, 2004 (29 MoReg 1196–1198). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No written or verbal comments were received concerning this proposed amendment during the public comment period.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 25—Hazardous Waste Management Commission
Chapter 17—Dry-Cleaning Environmental Response Trust Fund

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission under section 260.905, RSMo 2000, the commission hereby withdraws a proposed rule as follows:

10 CSR 25-17.010 Applicability **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on May 17, 2004 (29 MoReg 794–795). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: During a September 16, 2004, Joint Committee on Administrative Rules meeting, Gary Marble of Associated Industries of Missouri provided opposition to the proposed rule and claimed it should be voided because the department did not have the Order of Rulemaking in place by the statutory deadline of July 1, 2002 (section 260.905, RSMo). The department, Hazardous Waste Management Commissioner Norella Huggins, Attorney David Shorr, and three (3) operators of dry cleaning facilities, provided comments in favor of the proposed rule. The Joint Committee disapproved the rules at the September 16, 2004 meeting, and consequently the commission decided to withdraw the rules.

A public hearing was held December 15, 2004. At the public hearing, the Department of Natural Resources staff explained the withdrawal of the rule. Mr. Gary Marble, Associated Industries of Missouri provided one (1) comment in favor of the withdrawal of this rulemaking. No other comments were received.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 25—Hazardous Waste Management Commission
Chapter 17—Dry-Cleaning Environmental Response Trust Fund

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission under section 260.905, RSMo 2000, the commission hereby withdraws a proposed rule as follows:

10 CSR 25-17.020 Definitions **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on May 17, 2004 (29 MoReg 795–796). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: During a September 16, 2004, Joint Committee on Administrative Rules meeting, Gary Marble of Associated Industries of Missouri provided opposition to the proposed rule and claimed it should be voided because the department did not have the Order of Rulemaking in place by the statutory deadline of July 1, 2002 (section 260.905, RSMo). The department, Hazardous Waste Management Commissioner Norella Huggins, Attorney David Shorr, and three (3) operators of dry cleaning facilities, provided comments in favor of the proposed rule. The Joint Committee disapproved the rules at the September 16, 2004 meeting, and consequently the commission decided to withdraw the rules.

A public hearing was held December 15, 2004. At the public hearing, the Department of Natural Resources staff explained the withdrawal of the rule. Mr. Gary Marble, Associated Industries of Missouri provided one (1) comment in favor of the withdrawal of this rulemaking. No other comments were received.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 25—Hazardous Waste Management Commission
Chapter 17—Dry-Cleaning Environmental Response Trust Fund

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission under section 260.905, RSMo 2000, the commission hereby withdraws a proposed rule as follows:

10 CSR 25-17.030 Registration and Surcharges **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on May 17, 2004 (29 MoReg 796–797). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: During a September 16, 2004, Joint Committee on Administrative Rules meeting, Gary Marble of Associated Industries of Missouri provided opposition to the proposed rule and claimed it should be voided because the department did not have the Order of Rulemaking in place by the statutory deadline of July 1, 2002 (section 260.905, RSMo). The department, Hazardous Waste Management Commissioner Norella Huggins,

Attorney David Shorr, and three (3) operators of dry cleaning facilities, provided comments in favor of the proposed rule. The Joint Committee disapproved the rules at the September 16, 2004 meeting, and consequently the commission decided to withdraw the rules.

A public hearing was held December 15, 2004. At the public hearing, the Department of Natural Resources staff explained the withdrawal of the rule. Mr. Gary Marble, Associated Industries of Missouri provided one (1) comment in favor of the withdrawal of this rulemaking. No other comments were received.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 25—Hazardous Waste Management Commission
Chapter 17—Dry-Cleaning Environmental Response Trust Fund

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission under section 260.905, RSMo 2000, the commission hereby withdraws a proposed rule as follows:

10 CSR 25-17.040 Reporting and Record Keeping **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on May 17, 2004 (29 MoReg 797–802). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: During a September 16, 2004, Joint Committee on Administrative Rules meeting, Gary Marble of Associated Industries of Missouri provided opposition to the proposed rule and claimed it should be voided because the department did not have the Order of Rulemaking in place by the statutory deadline of July 1, 2002 (section 260.905, RSMo). The department, Hazardous Waste Management Commissioner Norella Huggins, Attorney David Shorr, and three (3) operators of dry cleaning facilities, provided comments in favor of the proposed rule. The Joint Committee disapproved the rules at the September 16, 2004 meeting, and consequently the commission decided to withdraw the rules.

A public hearing was held December 15, 2004. At the public hearing, the Department of Natural Resources staff explained the withdrawal of the rule. Mr. Gary Marble, Associated Industries of Missouri provided one (1) comment in favor of the withdrawal of this rulemaking. No other comments were received.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 25—Hazardous Waste Management Commission
Chapter 17—Dry-Cleaning Environmental Response Trust Fund

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission under section 260.905, RSMo 2000, the commission hereby withdraws a proposed rule as follows:

10 CSR 25-17.050 Reporting of Releases and Existing Contamination **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on May 17, 2004 (29 MoReg 803–809). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: During a September 16, 2004, Joint Committee on Administrative Rules meeting, Gary Marble of Associated Industries of Missouri provided opposition to the proposed rule and claimed it should be voided because the department did not have the Order of Rulemaking in place by the statutory deadline of July 1, 2002 (section 260.905, RSMo). The department, Hazardous Waste Management Commissioner Norella Huggins, Attorney David Shorr, and three (3) operators of dry cleaning facilities, provided comments in favor of the proposed rule. The Joint Committee disapproved the rules at the September 16, 2004 meeting, and consequently the commission decided to withdraw the rules.

A public hearing was held December 15, 2004. At the public hearing, the Department of Natural Resources staff explained the withdrawal of the rule. Mr. Gary Marble, Associated Industries of Missouri provided one (1) comment in favor of the withdrawal of this rulemaking. No other comments were received.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 25—Hazardous Waste Management Commission
Chapter 17—Dry-Cleaning Environmental Response Trust Fund

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission under section 260.905, RSMo 2000, the commission hereby withdraws a proposed rule as follows:

10 CSR 25-17.060 Site Prioritization and Completion **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on May 17, 2004 (29 MoReg 810). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: During a September 16, 2004, Joint Committee on Administrative Rules meeting, Gary Marble of Associated Industries of Missouri provided opposition to the proposed rule and claimed it should be voided because the department did not have the Order of Rulemaking in place by the statutory deadline of July 1, 2002 (section 260.905, RSMo). The department, Hazardous Waste Management Commissioner Norella Huggins, Attorney David Shorr, and three (3) operators of dry cleaning facilities, provided comments in favor of the proposed rule. The Joint Committee disapproved the rules at the September 16, 2004 meeting, and consequently the commission decided to withdraw the rules.

A public hearing was held December 15, 2004. At the public hearing, the Department of Natural Resources staff explained the withdrawal of the rule. Mr. Gary Marble, Associated Industries of Missouri provided one (1) comment in favor of the withdrawal of this rulemaking. No other comments were received.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 25—Hazardous Waste Management Commission
Chapter 17—Dry-Cleaning Environmental Response Trust Fund

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission under section 260.905, RSMo 2000, the commission hereby withdraws a proposed rule as follows:

10 CSR 25-17.070 Closure of Facilities **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on May 17, 2004 (29 MoReg 810–816). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: During a September 16, 2004, Joint Committee on Administrative Rules meeting, Gary Marble of Associated Industries of Missouri provided opposition to the proposed rule and claimed it should be voided because the department did not have the Order of Rulemaking in place by the statutory deadline of July 1, 2002 (section 260.905, RSMo). The department, Hazardous Waste Management Commissioner Norella Huggins, Attorney David Shorr, and three (3) operators of dry cleaning facilities, provided comments in favor of the proposed rule. The Joint Committee disapproved the rules at the September 16, 2004 meeting, and consequently the commission decided to withdraw the rules.

A public hearing was held December 15, 2004. At the public hearing, the Department of Natural Resources staff explained the withdrawal of the rule. Mr. Gary Marble, Associated Industries of Missouri provided one (1) comment in favor of the withdrawal of this rulemaking. No other comments were received.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 25—Hazardous Waste Management Commission
Chapter 17—Dry-Cleaning Environmental Response Trust Fund

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission under section 260.905, RSMo 2000, the commission hereby withdraws a proposed rule as follows:

10 CSR 25-17.080 Site Characterization and Corrective Action **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on May 17, 2004 (29 MoReg 817–823). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: During a September 16, 2004, Joint Committee on Administrative Rules meeting, Gary Marble of Associated Industries of Missouri provided opposition to the proposed rule and claimed it should be voided because the department did not have the Order of Rulemaking in place by the statutory deadline of July 1, 2002 (section 260.905, RSMo). The department, Hazardous Waste Management Commissioner Norella Huggins, Attorney David Shorr, and three (3) operators of dry cleaning facilities, provided comments in favor of the proposed rule. The Joint Committee disapproved the rules at the September 16, 2004 meeting, and consequently the commission decided to withdraw the rules.

A public hearing was held December 15, 2004. At the public hearing, the Department of Natural Resources staff explained the withdrawal of the rule. Mr. Gary Marble, Associated Industries of Missouri provided one (1) comment in favor of the withdrawal of this rulemaking. No other comments were received.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 25—Hazardous Waste Management Commission
Chapter 17—Dry-Cleaning Environmental Response Trust Fund

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission under section 260.905, RSMo 2000, the commission hereby withdraws a proposed rule as follows:

10 CSR 25-17.090 Application Procedures **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on May 17, 2004 (29 MoReg 824–829). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: During a September 16, 2004, Joint Committee on Administrative Rules meeting, Gary Marble of Associated Industries of Missouri provided opposition to the proposed rule and claimed it should be voided because the department did not have the Order of Rulemaking in place by the statutory deadline of July 1, 2002 (section 260.905, RSMo). The department, Hazardous Waste Management Commissioner Norella Huggins, Attorney David Shorr, and three (3) operators of dry cleaning facilities, provided comments in favor of the proposed rule. The Joint Committee disapproved the rules at the September 16, 2004 meeting, and consequently the commission decided to withdraw the rules.

A public hearing was held December 15, 2004. At the public hearing, the Department of Natural Resources staff explained the withdrawal of the rule. Mr. Gary Marble, Associated Industries of Missouri provided one (1) comment in favor of the withdrawal of this rulemaking. No other comments were received.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 25—Hazardous Waste Management Commission
Chapter 17—Dry-Cleaning Environmental Response Trust Fund

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission under section 260.905, RSMo 2000, the commission hereby withdraws a proposed rule as follows:

10 CSR 25-17.100 Participation and Eligibility for Funding **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on May 17, 2004 (29 MoReg 830). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: During a September 16, 2004, Joint Committee on Administrative Rules meeting, Gary Marble of Associated Industries of Missouri provided opposition to the proposed rule and claimed it should be voided because the department did not have the Order of Rulemaking in place by the statutory deadline of July 1, 2002 (section 260.905, RSMo). The department, Hazardous Waste Management Commissioner Norella Huggins, Attorney David Shorr, and three (3) operators of dry cleaning facilities, provided comments in favor of the proposed rule. The Joint Committee disapproved the rules at the September 16, 2004 meeting, and consequently the commission decided to withdraw the rules.

A public hearing was held December 15, 2004. At the public hearing, the Department of Natural Resources staff explained the withdrawal of the rule. Mr. Gary Marble, Associated Industries of Missouri provided one (1) comment in favor of the withdrawal of this rulemaking. No other comments were received.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 25—Hazardous Waste Management Commission
Chapter 17—Dry-Cleaning Environmental Response Trust Fund

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission under section 260.905, RSMo 2000, the commission hereby withdraws a proposed rule as follows:

10 CSR 25-17.110 Eligible Costs **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on May 17, 2004 (29 MoReg 830–831). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: During a September 16, 2004, Joint Committee on Administrative Rules meeting, Gary Marble of Associated Industries of Missouri provided opposition to the proposed rule and claimed it should be voided because the department did not have the Order of Rulemaking in place by the statutory deadline of July 1, 2002 (section 260.905, RSMo). The department, Hazardous Waste Management Commissioner Norella Huggins, Attorney David Shorr, and three (3) operators of dry cleaning facilities, provided comments in favor of the proposed rule. The Joint Committee disapproved the rules at the September 16, 2004 meeting, and consequently the commission decided to withdraw the rules.

A public hearing was held December 15, 2004. At the public hearing, the Department of Natural Resources staff explained the withdrawal of the rule. Mr. Gary Marble, Associated Industries of Missouri provided one (1) comment in favor of the withdrawal of this rulemaking. No other comments were received.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 25—Hazardous Waste Management Commission
Chapter 17—Dry-Cleaning Environmental Response Trust Fund

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission under section 260.905, RSMo 2000, the commission hereby withdraws a proposed rule as follows:

10 CSR 25-17.120 Payment of Deductible and Limits on Payments **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on May 17, 2004 (29 MoReg 831–832). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: During a September 16, 2004, Joint Committee on Administrative Rules meeting, Gary Marble of Associated Industries of Missouri provided opposition to the proposed rule and claimed it should be voided because the department did not have the Order of Rulemaking in place by the statutory deadline of July 1, 2002 (section 260.905, RSMo). The department, Hazardous Waste Management Commissioner Norella Huggins, Attorney David Shorr, and three (3) operators of dry cleaning facilities, provided comments in favor of the proposed rule. The Joint Committee disapproved the rules at the September 16, 2004 meeting, and consequently the commission decided to withdraw the rules.

A public hearing was held December 15, 2004. At the public hearing, the Department of Natural Resources staff explained the withdrawal of the rule. Mr. Gary Marble, Associated Industries of Missouri provided one (1) comment in favor of the withdrawal of this rulemaking. No other comments were received.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 25—Hazardous Waste Management Commission
Chapter 17—Dry-Cleaning Environmental Response Trust Fund

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission under section 260.905, RSMo 2000, the commission hereby withdraws a proposed rule as follows:

10 CSR 25-17.130 Suspension of Collection of Surcharges; Reinstatement **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on May 17, 2004 (29 MoReg 832). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: During a September 16, 2004, Joint Committee on Administrative Rules meeting, Gary Marble of Associated Industries of Missouri provided opposition to the proposed rule and claimed it should be voided because the department did not have the Order of Rulemaking in place by the statutory deadline of July 1, 2002 (section 260.905, RSMo). The department, Hazardous Waste Management Commissioner Norella Huggins, Attorney David Shorr, and three (3) operators of dry cleaning facilities, provided comments in favor of the proposed rule. The Joint Committee disapproved the rules at the September 16, 2004 meeting, and consequently the commission decided to withdraw the rules.

A public hearing was held December 15, 2004. At the public hearing, the Department of Natural Resources staff explained the withdrawal of the rule. Mr. Gary Marble, Associated Industries of Missouri provided one (1) comment in favor of the withdrawal of this rulemaking. No other comments were received.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 25—Hazardous Waste Management Commission
Chapter 17—Dry-Cleaning Environmental Response Trust Fund

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission under section 260.905, RSMo 2000, the commission hereby withdraws a proposed rule as follows:

10 CSR 25-17.140 General Reimbursement Procedures **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on May 17, 2004 (29 MoReg 832–833). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: During a September 16, 2004, Joint Committee on Administrative Rules meeting, Gary Marble of Associated Industries of Missouri provided opposition to the proposed rule and claimed it should be voided because the department

did not have the Order of Rulemaking in place by the statutory deadline of July 1, 2002 (section 260.905, RSMo). The department, Hazardous Waste Management Commissioner Norella Huggins, Attorney David Shorr, and three (3) operators of dry cleaning facilities, provided comments in favor of the proposed rule. The Joint Committee disapproved the rules at the September 16, 2004 meeting, and consequently the commission decided to withdraw the rules.

A public hearing was held December 15, 2004. At the public hearing, the Department of Natural Resources staff explained the withdrawal of the rule. Mr. Gary Marble, Associated Industries of Missouri provided one (1) comment in favor of the withdrawal of this rulemaking. No other comments were received.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 25—Hazardous Waste Management Commission
Chapter 17—Dry-Cleaning Environmental Response Trust Fund

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission under section 260.905, RSMo 2000, the commission hereby withdraws a proposed rule as follows:

10 CSR 25-17.150 Claims **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on May 17, 2004 (29 MoReg 833–838). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: During a September 16, 2004, Joint Committee on Administrative Rules meeting, Gary Marble of Associated Industries of Missouri provided opposition to the proposed rule and claimed it should be voided because the department did not have the Order of Rulemaking in place by the statutory deadline of July 1, 2002 (section 260.905, RSMo). The department, Hazardous Waste Management Commissioner Norella Huggins, Attorney David Shorr, and three (3) operators of dry cleaning facilities, provided comments in favor of the proposed rule. The Joint Committee disapproved the rules at the September 16, 2004 meeting, and consequently the commission decided to withdraw the rules.

A public hearing was held December 15, 2004. At the public hearing, the Department of Natural Resources staff explained the withdrawal of the rule. Mr. Gary Marble, Associated Industries of Missouri provided one (1) comment in favor of the withdrawal of this rulemaking. No other comments were received.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 25—Hazardous Waste Management Commission
Chapter 17—Dry-Cleaning Environmental Response Trust Fund

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission under section 260.905, RSMo 2000, the commission hereby withdraws a proposed rule as follows:

10 CSR 25-17.160 Notification of Abandoned Sites **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on May 17, 2004 (29 MoReg 839). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: During a September 16, 2004, Joint Committee on Administrative Rules meeting, Gary Marble of Associated Industries of Missouri provided opposition to the proposed rule and claimed it should be voided because the department did not have the Order of Rulemaking in place by the statutory deadline of July 1, 2002 (section 260.905, RSMo). The department, Hazardous Waste Management Commissioner Norella Huggins, Attorney David Shorr, and three (3) operators of dry cleaning facilities, provided comments in favor of the proposed rule. The Joint Committee disapproved the rules at the September 16, 2004 meeting, and consequently the commission decided to withdraw the rules.

A public hearing was held December 15, 2004. At the public hearing, the Department of Natural Resources staff explained the withdrawal of the rule. Mr. Gary Marble, Associated Industries of Missouri provided one (1) comment in favor of the withdrawal of this rulemaking. No other comments were received.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 25—Hazardous Waste Management Commission
Chapter 17—Dry-Cleaning Environmental Response Trust Fund

ORDER OF RULEMAKING

By the authority vested in the Hazardous Waste Management Commission under section 260.905, RSMo 2000, the commission hereby withdraws a proposed rule as follows:

10 CSR 25-17.170 Violations of Dry Cleaning Remediation Laws **is withdrawn**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on May 17, 2004 (29 MoReg 839). This proposed rule is withdrawn.

SUMMARY OF COMMENTS: During a September 16, 2004, Joint Committee on Administrative Rules meeting, Gary Marble of Associated Industries of Missouri provided opposition to the proposed rule and claimed it should be voided because the department did not have the Order of Rulemaking in place by the statutory deadline of July 1, 2002 (section 260.905, RSMo). The department, Hazardous Waste Management Commissioner Norella Huggins, Attorney David Shorr, and three (3) operators of dry cleaning facilities, provided comments in favor of the proposed rule. The Joint Committee disapproved the rules at the September 16, 2004 meeting, and consequently the commission decided to withdraw the rules.

A public hearing was held December 15, 2004. At the public hearing, the Department of Natural Resources staff explained the withdrawal of the rule. Mr. Gary Marble, Associated Industries of Missouri provided one (1) comment in favor of the withdrawal of this rulemaking. No other comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 3—Fireworks

ORDER OF RULEMAKING

By the authority vested in the Missouri Division of Fire Safety under section 320.111, RSMo 2000, the division rescinds a rule as follows:

11 CSR 40-3.010 Fireworks—Licenses, Sales and Penalties **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 1, 2004 (29 MoReg 1455). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 40—Division of Fire Safety
Chapter 3—Fireworks

ORDER OF RULEMAKING

By the authority vested in the Missouri Division of Fire Safety under section 320.111, RSMo 2000, the division adopts a rule as follows:

11 CSR 40-3.010 is adopted.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 1, 2004 (29 MoReg 1455–1463). Those sections with changes are reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: The Division of Fire Safety received comments on the proposed rule from three (3) individuals.

COMMENT: Charles E. Wald, President, Wald & Co., Inc. requested that the recertification/renewal fee in subparagraph (9)(B)6.C. for a licensed/pyrotechnic display operator be reduced from one hundred dollars ($100) to fifty dollars ($50).
RESPONSE: The division has considered many factors to project the costs to administer the licensing program to include but not limited to development and implementation of promulgated rules and regulations; development of database; implement filing system; developing test banks; validation of test banks; etc. Based upon these projected costs and an anticipated five hundred (500) licensed operators, the division has determined a three (3)-year average cost per operator per year to be approximately twenty-eight dollars and seventy-six cents ($28.76). Current cost of a three (3)-year license per operator is thirty-three dollars ($33) per year. No changes have been made to the rule as a result of this comment.

COMMENT: Tom Dixon with Atomic Fireworks Inc. and Mike Ingram with Fireworks Over America, Inc. requested that text be added in subsection (1)(C) to prevent a rule change from being required if the referenced document would change.
RESPONSE: Per 2004 legislation (House Bill 1616) a referenced document cannot include any later amendments or additions. No changes have been made to the rule as a result of this comment.

COMMENT: Tom Dixon with Atomic Fireworks Inc. and Mike Ingram with Fireworks Over America, Inc. requested that text be deleted in subsection (1)(N) to remove specific information relating to referenced national standards.
RESPONSE AND EXPLANATION OF CHANGE: Per 2004 legislation (House Bill 1616) a referenced document shall fully identify the incorporated material by publisher, address, and date in order to specify how a copy of the material may be obtained. However, more specific text will be added to ensure this section is clear in that the referenced documents are specific to the intent of subsection (1)(N).

COMMENT: Tom Dixon with Atomic Fireworks Inc. and Mike Ingram with Fireworks Over America, Inc. requested text be added to subsection (2)(A) to clarify reference to the sales of consumer fireworks.
COMMENT: Mike Ingram with Fireworks Over America, Inc. identified an error in subsection (2)(A) where "theatrical" was included.
RESPONSE AND EXPLANATION OF CHANGE: Subsection (2)(A) will be changed to clarify the intent to be consumer fireworks and correct the error.

COMMENT: Tom Dixon with Atomic Fireworks Inc. suggested an editorial change in subsection (2)(D) to add a plural notation and in subsection (2)(M) to delete a plural notation on the word "dollars."
RESPONSE AND EXPLANATION OF CHANGE: Subsection (2)(D) will be changed to add a plural notation to "permit" and section (2)(M) will be changed to delete the plural notation to "dollars."

COMMENT: Tom Dixon with Atomic Fireworks Inc. and Mike Ingram with Fireworks Over America, Inc. requested an editorial change to paragraph (3)(A)4. for clarification.
RESPONSE AND EXPLANATION OF CHANGE: Paragraph (3)(A)4. will be changed to clarify the intent.

COMMENT: Tom Dixon with Atomic Fireworks Inc. requests to add text to subsection (4)(B) to clarify who a licensed distributor may sell to without being required to obtain any additional permit(s).
RESPONSE AND EXPLANATION OF CHANGE: Subsection (4)(B) will be changed to clarify that no additional permit(s) is required to sell consumer fireworks to the general public.

COMMENT: Tom Dixon with Atomic Fireworks Inc. requests deletion of "wholesalers" in subsection (4)(E).
RESPONSE AND EXPLANATION OF CHANGE: Subsection (4)(E) will be changed by deleting "wholesalers" due to the fact that a wholesaler cannot sell fireworks at retail.

COMMENT: Mike Ingram with Fireworks Over America, Inc. requested text be added to subsection (4)(E) to clarify this applies to nonpermitted persons or entities.
RESPONSE AND EXPLANATION OF CHANGE: Subsection (4)(E) will be changed to reflect nonpermitted persons or entities are included in this section.

COMMENT: Tom Dixon with Atomic Fireworks Inc. has questioned how this section will address existing structures in relation to building/fire codes in subsection (4)(F).
RESPONSE: The Division of Fire Safety has no authority to dictate how a local governmental jurisdiction administers local code/ordinance requirements per 320.121.1, RSMo. If the structure is located within a jurisdiction that has adopted a specific building/fire code or ordinance then compliance with that code/ordinance must be verified to the division. No changes have been made to this rule as a result of this comment.

COMMENT: Tom Dixon with Atomic Fireworks Inc. requested text be added to subsection (5)(B) to include U.S. Department of Transportation classification number.
RESPONSE AND EXPLANATION OF CHANGE: Subsection (5)(B) will be changed by adding the classification number for consumer fireworks.

COMMENT: Tom Dixon with Atomic Fireworks Inc. and Mike Ingram with Fireworks Over America, Inc. requested reference to *Code of State Regulations* be deleted from subsection (5)(F) due to their belief of conflict with "state fireworks regulations."

RESPONSE: This is an editorial issue; the terminology "state fireworks regulations" is one and the same as *Code of State Regulations*. The document containing state fireworks rules/regulations is the *Code of State Regulations*. No changes have been made to the rules as a result of this comment.

COMMENT: Tom Dixon with Atomic Fireworks Inc. has requested that paragraphs (7)(G)3. and (7)(G)4. be deleted relating to emergency lighting requirements in seasonal retail sales locations.
RESPONSE AND EXPLANATION OF CHANGE: No changes to paragraph (7)(G)3. of the rule will be made as a result of this comment. Paragraph (7)(G)4. will be changed to identify the minimum size of a seasonal retail sales location that will be required to have emergency lighting.

COMMENT: Mike Ingram with Fireworks Over America, Inc. expressed concern over paragraph (7)(G)4. relating to the requirement for emergency lighting as deemed necessary by the authority having jurisdiction. Mr. Ingram believes the text seems to give a local fire inspector or authority having jurisdiction the opportunity to overuse his/her authority if they are anti-fireworks.
RESPONSE AND EXPLANATION OF CHANGE: The Division of Fire Safety cannot prohibit a local governmental jurisdiction from adopting a more stringent code/ordinance per 321.121.1, RSMo. The reference to a "fire inspector" is referring to a Division of Fire Safety inspector. Paragraph (7)(G)4. will be changed to clarify reference to a division fire inspector.

COMMENT: Tom Dixon with Atomic Fireworks Inc. and Mike Ingram with Fireworks Over America, Inc. requested to add text in paragraph (7)(I)5. to include display fireworks not being allowed to be sold with consumer fireworks.
RESPONSE AND EXPLANATION OF CHANGE: Paragraph (7)(I)5. will be changed to include display fireworks.

COMMENT: Tom Dixon with Atomic Fireworks Inc. requested to add text in paragraph (10)(A)5. in reference to fireworks being exposed to direct sunlight by allowing this if the product is in its original packages.
RESPONSE AND EXPLANATION OF CHANGE: This section refers to 320.146.1, RSMo which includes text relating to fireworks in the original package. Paragraph (10)(A)5. will be changed to be consistent with statutory language.

COMMENT: Tom Dixon with Atomic Fireworks Inc. requested to delete paragraph (10)(A)16. citing this is not a U.S. Department of Transportation requirement.
RESPONSE: 320.131, RSMo prohibits the sale of consumer fireworks that do not bear U.S. Department of Transportation label UN0336, 1.4G. No changes have been made to the rule as a result of this comment.

COMMENT: Mike Ingram with Fireworks Over America, Inc. expressed concern that paragraph (10)(C)8. is an excessive penalty for first time offenders.
RESPONSE AND EXPLANATION OF CHANGE: Paragraph (10)(C)8. will be moved to paragraph (10)(A)18. making this violation a written warning for first time offense.

11 CSR 40-3.010 Fireworks—Licensing, Permits, Sales, Inspection, and Penalties

(1) The following definitions shall be used in interpreting this rule:

(N) NFPA, National Fire Protection Association, Standards 101 (2003 edition) as used in setting standards for proximate fireworks; 1123 (2000 edition); 1124 (2003 edition) as used in setting standards for display and proximate fireworks; and 1126 (2001 edition), #1 Batterymarch Park, PO Box 9101, Quincy, MA 02269, as incorporated by reference; an international codes and standards organization;

(2) General Requirements: Licenses, Permits and Fees.

(A) Each firm or person engaged in the manufacture, transportation, wholesale or retail sales of consumer fireworks, public displays utilizing fireworks 1.3G, proximate and consumer fireworks 1.4G, proximate fireworks 1.4S theatrical, pyrotechnic special effects operators, licensed display fireworks operator shall have an applicable license or permit issued by the state fire marshal.

1. License by type:

A. Licensed operator, a fee of one hundred dollars ($100) for three (3)-year license; and

B. Pyrotechnic or special effects operator, a fee of one hundred dollars ($100) for three (3)-year license.

2. Permits by type:

A. Manufacturer, fee of seven hundred seventy-five dollars ($775) per calendar year per location;

B. Distributor, fee of seven hundred seventy-five dollars ($775) per calendar year per location;

C. Wholesaler, fee of two hundred seventy-five dollars ($275) per calendar year per location;

D. Jobber, a fee of five hundred twenty-five dollars ($525) per calendar year per location;

E. Seasonal retailer, a fee of fifty dollars ($50) per calendar year per sales location;

F. Display fireworks, a fee of one hundred dollars ($100) per calendar year per location;

G. Proximate fireworks display, a fee of one hundred dollars ($100) per calendar year per location.

(D) Seasonal retail permit(s) shall be valid from the twentieth day of June through the tenth day of July of the same year and the period beginning on the twentieth day of December through the second day of January of the next year.

(M) In addition to any other penalty, any person who manufacturers, sells, offers for sale, ships or causes to be shipped into or caused to be shipped into Missouri for use in Missouri any items of fireworks without first having obtained the applicable permit or license shall be assessed a civil penalty of up to a one thousand dollar ($1,000) fine for each day of operation up to a maximum of ten thousand dollars ($10,000).

(3) Applications for Permit: Manufacturer, Distributor, Wholesaler, Jobber, Seasonal Retail.

(A) Applications for a permit shall be on forms provided by the state fire marshal and shall be accompanied by the appropriate fee and documentation as required.

1. Copy of Missouri retail sales tax license.

2. Copy of current certificate of "No Tax Due" for the preceding year obtained from Missouri Department of Revenue, except if the applicant is pursuing any proper remedy at law challenging the amount, collection, or assessment of any sales tax.

3. If applicable, copy of "Certificate of Good Standing" from Missouri Secretary of State.

4. If applicable, copy of federal license or permit.

(4) Requirements: Manufacturer, Distributor, Jobber or Wholesaler.

(A) A holder of a manufacturer's permit shall not be required to have any additional permits in order to sell to distributors, wholesalers, jobbers or seasonal retailers, or to sell display or proximate fireworks.

(B) A holder of a distributor's permit shall not be required to have any additional permit in order to sell consumer fireworks to wholesalers, jobbers, seasonal retailers, consumers during the fireworks season or to sell display or proximate fireworks.

(E) Any sales by jobbers to nonpermitted persons or entities during any period of time other than the fireworks season as defined in section 320.106(3), RSMo shall be to nonresidents of Missouri, or

to residents of Missouri only after a reasonable inquiry and a waiver signed by the buyer on a form provided by the state fire marshal indicating that the fireworks are for use outside of Missouri if the sale is a retail transaction.

(5) Requirements: Seasonal Retail Sales.

(A) A seasonal retail permit shall be required for each retail sales location.

(B) Consumer fireworks UN0336, 1.4G shall be sold to the general public only from permitted seasonal retail sites and only during the fireworks season as defined in section (1) of this rule.

(7) Requirements: Fire Safety Inspection—Retail Sales.

(G) Exit Signs and Emergency Lighting.

1. Exit signs shall be required to be self-luminous or internally or externally illuminated.

2. Exit signs shall not be required to be illuminated in tents or stands that are not open for business after dusk or in temporary seasonal retail sales stands where the interior is not accessible to the public.

3. Emergency lighting shall not be required in tents or stands that are not open for business after dusk or for temporary seasonal retail sales stands where the interior is not accessible to the public.

4. Emergency lighting shall be required in seasonal retail sales locations when the retail sales area is eight hundred (800) square feet or greater.

(I) Prohibited Activity/Items.

1. The retail sales of pest control devices, including their related storage and display shall be prohibited.

2. No electronic pest control device(s) shall be located inside a seasonal retail sales location.

3. The consumption or possession of alcoholic beverages in any seasonal retail sales location is prohibited during business hours.

4. Any person selling fireworks shall not knowingly sell consumer fireworks to any person who is obviously under the influence of alcohol or drugs.

5. Proximate and display fireworks shall not be allowed to be sold with consumer fireworks.

(10) Violations.

(A) A permittee will receive a written warning from the state fire marshal for violation of any of the following:

1. Failing to properly display a No Smoking sign(s);

2. Failing to properly display a No Smoking sign(s) of sufficient size;

3. Failing to properly display a permit or license;

4. Selling or offering for sale fireworks that are not properly labeled;

5. Exposing fireworks not in the original package to direct sunlight while displayed or unattended, as defined by section 320.146.1, RSMo;

6. Leaving unattended fireworks accessible to the public;

7. Attempting to make or making a sale of fireworks out of season as defined in section 320.106(9), RSMo to someone for use or distribution within the state of Missouri;

8. Knowingly allowing an open flame or smoking within twenty-five feet (25') of a place where fireworks are manufactured, stored, kept, or offered for sale;

9. Selling to a child under the age of fourteen (14) who is not in the presence of his/her parent or guardian;

10. Receiving fireworks without a permit if the permittee was permitted but failed to renew;

11. Selling fireworks without a permit if the permittee was permitted but failed to renew;

12. Selling from other than a permanent structure, except for retail sales during fireworks seasons;

13. Storing fireworks too close to volatile liquids or gases, as defined by section 320.146(2), RSMo;

14. Selling or shipping fireworks to a consumer within a city or county lawfully prohibiting the sale or possession of fireworks pursuant to section 320.121, RSMo;

15. Employing a person less than sixteen (16) years of age who is unsupervised;

16. Selling or offering for sale or displaying fireworks to consumers that are marked other than UN0336, 1.4G;

17. Failure of distributors and manufacturers to retain copies of applicable permit(s) or license(s) issued for display and/or proximate fireworks transactions for one (1) year after the transaction;

18. Selling fireworks for resale in this state to a distributor, manufacturer, jobber, wholesaler or seasonal retailer who has not first obtained their current permits as required by law.

(B) Subsequent violation of any of the acts set forth in subsection (10)(A) will result in the suspension or revocation of the permit(s) of the permittee for a period as determined by the state fire marshal.

(C) Violation of any of the following laws or regulations may result in the suspension or revocation of the permit(s) for a period not to exceed three (3) years and/or the refusal of the fire marshal to renew or issue a permit(s) to the permittee or owner:

1. Selling or improperly possessing fireworks while the permit or license has been suspended or revoked;

2. Allowing another person or business to use or display the license of a licensee;

3. Possessing or manufacturing illegal fireworks or selling or offering for sale illegal fireworks as defined in section 320.136, RSMo;

4. Failing or refusing to allow a reasonable inspection of any premises and all portions of buildings where fireworks are being stored or are being offered for sale. A reasonable request is one made either during daylight hours or while the premises or building are open for business;

5. Failing to fully cooperate with a reasonable request during an inspection;

6. Failure to obtain a permit for display or proximate fireworks site;

7. Performing a display or proximate fireworks display without having obtained a licensed operator or pyrotechnic operator permit from the Missouri State Fire Marshal;

8. Failure of the applicant to obtain all required permit(s) and/or license(s) required as per 320.111(1), RSMo.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 1—Organization and Administration

ORDER OF RULEMAKING

By the authority vested in the Missouri Gaming Commission under sections 313.004 and 313.805, RSMo 2000, the commission adopts a rule as follows:

11 CSR 45-1.100 Waivers and Variances **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 1, 2004 (29 MoReg 1464). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses

ORDER OF RULEMAKING

By the authority vested in the Missouri Gaming Commission under sections 313.004 and 313.805, RSMo 2000, the commission amends a rule as follows:

11 CSR 45-4.260 Occupational Licenses **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 1, 2004 (29 MoReg 1464). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 12—Liquor Control

ORDER OF RULEMAKING

By the authority vested in the Missouri Gaming Commission under sections 313.004 and 313.805, RSMo 2000 and 313.840, RSMo Supp. 2003, the commission amends a rule as follows:

11 CSR 45-12.090 Rules of Liquor Control **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 1, 2004 (29 MoReg 1464–1465). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle

ORDER OF RULEMAKING

By the authority vested in the director of revenue under section 474.250, RSMo 2000, the director amends a rule as follows:

12 CSR 10-23.335 Issuance of Title to a Surviving Spouse or Unmarried Minor Children of a Decedent **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1547). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle

ORDER OF RULEMAKING

By the authority vested in the director of revenue under sections 301.144.2 and 301.444, RSMo 2000, the director rescinds a rule as follows:

12 CSR 10-23.375 Fire Department License Plates **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1547). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 23—Motor Vehicle

ORDER OF RULEMAKING

By the authority vested in the director of revenue under sections 301.219, 301.221 and 301.229, RSMo 2000, the director adopts a rule as follows:

12 CSR 10-23.465 Issuance of Biennial Salvage Business Licenses **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1547–1549). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 26—Dealer Licensure

ORDER OF RULEMAKING

By the authority vested in the director of revenue under sections 301.553 and 301.562, RSMo 2000, the director rescinds a rule as follows:

12 CSR 10-26.130 Review of License Denial or Disciplinary Action **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1550). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 26—Dealer Licensure

ORDER OF RULEMAKING

By the authority vested in the director of revenue under section 301.553, RSMo 2000, the director rescinds a rule as follows:

12 CSR 10-26.140 Hearing Procedures **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1550). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 26—Dealer Licensure

ORDER OF RULEMAKING

By the authority vested in the director of revenue under section 301.553, RSMo 2000, the director rescinds a rule as follows:

12 CSR 10-26.150 Designated Hearing Officer **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1550). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 26—Dealer Licensure

ORDER OF RULEMAKING

By the authority vested in the director of revenue under section 301.553, RSMo 2000, the director rescinds a rule as follows:

12 CSR 10-26.160 Waiver of Hearing **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1550). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 26—Dealer Licensure

ORDER OF RULEMAKING

By the authority vested in the director of revenue under section 301.553, RSMo 2000, the director rescinds a rule as follows:

12 CSR 10-26.170 Prehearing Conferences and Stipulations **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1551). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 103—Sales/Use Tax—Imposition of Tax

ORDER OF RULEMAKING

By the authority vested in the director of revenue under section 144.270, RSMo 2000, the director adopts a rule as follows:

12 CSR 10-103.210 Auctioneers and Other Agents Selling Tangible Personal Property **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1551–1553). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 110—Fees

ORDER OF RULEMAKING

By the authority vested in the Department of Social Services, Family Support Division under section 454.400.2(5), RSMo Supp. 2003, the division adopts a rule as follows:

13 CSR 40-110.020 Federal Income Tax Refund Offset Fee **is adopted**.

A notice of proposed rulemaking containing the text of the proposed rule was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1554–1556). No changes have been made in the text of the proposed rule, so it is not reprinted here. This proposed rule becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 15—Hospital Program

ORDER OF RULEMAKING

By the authority vested in the Division of Medical Services under sections 208.201, 208.453 and 208.455, RSMo 2000, the director amends a rule as follows:

13 CSR 70-15.110 Federal Reimbursement Allowance (FRA) **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on November 1, 2004 (29 MoReg 1731–1732). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 10—County Employees' Defined Contribution Plan

ORDER OF RULEMAKING

By the authority vested in the County Employees' Retirement Board under sections 50.1090, RSMo Supp. 2003 and 50.1250, RSMo 2000, the board amends a rule as follows:

16 CSR 50-10.050 Distribution of Accounts **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 1, 2004 (29 MoReg 1469–1470). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Senior Services and Regulation
Chapter 83—Definition of Terms

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under sections 198.006, RSMo Supp. 2004 and 198.009, RSMo 2000, the department amends a rule as follows:

19 CSR 30-83.010 Definition of Terms **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1567–1568). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after the publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Health Standards and Licensure
Chapter 89—Specialized Long-Term Care Facilities or Special Care Units

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under sections 198.009 and 198.079, RSMo 2000, the department rescinds a rule as follows:

19 CSR 30-89.010 Pediatric Nursing Facilities **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1568–1569). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after the publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Senior Services and Regulation
Chapter 90—Adult Day Care Program Licensure

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under sections 660.050, RSMo Supp. 2003 and 660.418, RSMo 2000, the department amends a rule as follows:

19 CSR 30-90.010 Definitions **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1569–1570). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after the publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Senior Services and Regulation
Chapter 90—Adult Day Care Program Licensure

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under sections 660.050, RSMo Supp. 2003 and 660.418, RSMo 2000, the department amends a rule as follows:

19 CSR 30-90.020 Licensure Requirements **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1570–1574). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after the publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Health Standards and Licensure
Chapter 90—Adult Day Care Program Licensure

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under section 660.050, RSMo Supp. 2003 and 660.418, RSMo 2000, the department rescinds a rule as follows:

19 CSR 30-90.030 Participants' Rights and Program Policies **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1574). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after the publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Senior Services and Regulation
Chapter 90—Adult Day Care Program Licensure

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under sections 660.050, RSMo Supp. 2003 and 660.418, RSMo 2000, the department amends a rule as follows:

19 CSR 30-90.040 Staffing Requirements **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1574–1578). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after the publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Senior Services and Regulation
Chapter 90—Adult Day Care Program Licensure

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under sections 660.050, RSMo Supp. 2003 and 660.418, RSMo 2000, the department amends a rule as follows:

19 CSR 30-90.050 Program Policies and Participant Care Requirements and Rights **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1579–1581). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after the publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Senior Services and Regulation
Chapter 90—Adult Day Care Program Licensure

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under sections 660.050, RSMo Supp. 2003 and 660.418, RSMo 2000, the department amends a rule as follows:

19 CSR 30-90.060 Record Keeping Requirements **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1581–1582). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after the publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Senior Services and Regulation
Chapter 90—Adult Day Care Program Licensure

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under sections 660.050, RSMo Supp. 2003 and 660.418, RSMo 2000, the department amends a rule as follows:

19 CSR 30-90.070 Fire Safety and Facility Physical Requirements **is amended**.

A notice of proposed rulemaking containing the text of the proposed amendment was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1582–1586). No changes have been made in the text of the proposed amendment, so it is not reprinted here. This proposed amendment becomes effective thirty (30) days after the publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Health Standards and Licensure
Chapter 90—Adult Day Care Program Licensure

ORDER OF RULEMAKING

By the authority vested in the Department of Health and Senior Services under sections 660.050, RSMo Supp. 2003 and 660.418, RSMo 2000, the department rescinds a rule as follows:

19 CSR 30-90.080 Fire Safety Requirements **is rescinded**.

A notice of proposed rulemaking containing the proposed rescission was published in the *Missouri Register* on October 15, 2004 (29 MoReg 1587). No changes have been made in the proposed rescission, so it is not reprinted here. This proposed rescission becomes effective thirty (30) days after the publication in the *Code of State Regulations*.

SUMMARY OF COMMENTS: No comments were received.

This section may contain notice of hearings, correction notices, public information notices, rule action notices, statements of actual costs and other items required to be published in the *Missouri Register* by law.

OFFICE OF THE GOVERNOR
STATE OF MISSOURI
JEFFERSON CITY
65101

MATT BLUNT
GOVERNOR

STATE CAPITOL
ROOM 216
(573) 751-3222

January 11, 2005

Robin Carnahan
Secretary of State
Administrative Rules Division
600 West Main Street
Jefferson City, Missouri 65102

Dear Secretary Carnahan,

RE: Notice of Termination
1 CSR 10-4.010(1)(E) State of Missouri Vendor Payroll Deductions

On January 11, 2005, I issued Executive Order 05-01 which rescinded Executive Order 01-09. That Executive Order purported to allow departments and agencies in the executive branch to enter into collective bargaining agreements with local unions. The rescission of Executive Order 01-09 removes any authority for collective bargaining agreements by departments and agencies within the executive branch. Pursuant to Executive Order 01-09, the Office of Administration promulgated 1 CSR 10-4.010(1)(E) to allow the automatic deduction of service fees from employees' paychecks. My action as Governor to rescind Executive Order 01-09 terminates 1 CSR 10-4.010(1)(E). Pursuant to section 536.022, RSMo, I am notifying you that 1 CSR 10-4.010(1)(E) is hereby terminated effective January 11, 2005. As provided in section 536.022.4, such notices shall be printed by the Secretary of State in the Missouri Register as soon as practicable, and codified in the Code of State Regulations regarding the termination of this subsection.

Thank you for your attention to this matter.

Sincerely,

Matt Blunt
Governor and
Acting Commissioner of Administration

cc: Joint Committee on Administrative Rules

JOINT COMMITTEE ON
JAN 12 2005
ADMINISTRATIVE RULES

Title 3—DEPARTMENT OF CONSERVATION
Division 10—Conservation Commission
Chapter 7—Wildlife Code: Hunting: Seasons, Methods, Limits

IN ADDITION

3 CSR 10-7.455 Turkeys: Seasons, Methods, Limits

As a matter of public information, the following dates and bag limits shall apply on turkey hunting seasons for 2005. These are based on the formula for season dates set out in subsections (1)(A), (1)(B) and (1)(D) of this rule in the *Code of State Regulations*, and action of the Conservation Commission on December 17, 2004, to annually establish the season length and bag limit of the spring and fall turkey hunting season.

Spring Season: The 2005 spring turkey hunting season will be twenty-one (21) days in length (from April 18 through May 8, 2005). A person possessing the prescribed turkey hunting permit may take two (2) male turkeys or turkeys with visible beard during the season; provided, only one (1) turkey may be taken during the first seven (7) days of the season and only one (1) turkey may be taken per day.

Fall Season: The 2005 fall season will be thirty-one (31) days in length from (October 1 through October 31). A person possessing the prescribed turkey hunting permit may take two (2) turkeys of either sex during the season except that a person at least six (6) but not older than fifteen (15) years of age who possesses a Youth Deer and Turkey Hunting Permit may take only one (1) turkey of either sex during the season.

Youth Spring Season: April 9–10, 2005.

Title 7—DEPARTMENT OF TRANSPORTATION
Division 10—Missouri Highways and Transportation Commission
Chapter 25—Motor Carrier Operations

IN ADDITION

7 CSR 10-25.010 Skill Performance Evaluation Certificates for Commercial Drivers

PUBLIC NOTICE

Public Notice and Request for Comments on Applications for Issuance of Skill Performance Evaluation Certificates to Intrastate Commercial Drivers with Diabetes Mellitus or Impaired Vision

SUMMARY: This notice publishes MoDOT's receipt of applications for the issuance of Skill Performance Evaluation (SPE) Certificates, from individuals who do not meet the physical qualification requirements in the Federal Motor Carrier Safety Regulations for drivers of commercial motor vehicles in Missouri intrastate commerce, because of impaired vision, or an established medical history or clinical diagnosis of diabetes mellitus currently requiring insulin for control. If granted, the SPE Certificates will authorize these individuals to qualify as drivers of commercial motor vehicles (CMVs), in intrastate commerce only, without meeting the vision standard prescribed in 49 CFR 391.41(b)(10), if applicable, or the diabetes standard prescribed in 49 CFR 391.41(b)(3).

DATES: Comments must be received at the address stated below, on or before March 2, 2005.

ADDRESSES: You may submit comments concerning an applicant, identified by the Application Number stated below, by any of the following methods:

- *E-mail: Kathy.Hatfield@modot.mo.gov*
- *Mail: PO Box 893, Jefferson City, MO 65102-0893*
- *Hand Delivery: 1320 Creek Trail Drive, Jefferson City, MO 65109*
- *Instructions:* All comments submitted must include the agency name and Application Number for this public notice. For detailed instructions on submitting comments, see the Public Participation heading of the Supplementary Information section of this notice. All comments received will be open and available for public inspection and MoDOT may publish those comments by any available means.

COMMENTS RECEIVED BECOME MoDOT PUBLIC RECORD

- By submitting any comments to MoDOT, the person authorizes MoDOT to publish those comments by any available means.
- *Docket:* For access to the department's file, to read background documents or comments received, 1320 Creek Trail Drive, Jefferson City, MO 65109, between 7:30 a.m. and 4 p.m., Monday through Friday, except state holidays.

FOR FURTHER INFORMATION CONTACT: Ms. Kathy Hatfield, Motor Carrier Specialist, (573) 522-9001, MoDOT Motor Carrier Services Division, PO Box 893, Jefferson City, MO 65102-0893. Office hours are from 7:30 a.m. to 4:00 p.m., CT, Monday through Friday, except state holidays.

SUPPLEMENTARY INFORMATION:

Public Participation
If you want us to notify you that we received your comments, please include a self-addressed, stamped envelope or postcard.

Background
The individuals listed in this notice have recently filed applications requesting MoDOT to issue SPE Certificates to exempt them from the physical qualification requirements relating to vision in 49 CFR 391.41(b)(10), or to diabetes in 49 CFR 391.41(b)(3), which otherwise apply to drivers of CMVs in Missouri intrastate commerce.

Under section 622.555, *Missouri Revised Statutes* (RSMo) Supp. 2002, MoDOT may issue a Skill Performance Evaluation Certificate, for not more than a two (2)-year period, if it finds that the applicant has the ability, while operating CMVs, to maintain a level of safety that is equivalent to or greater than the driver qualification standards of 49 CFR 391.41. Upon application, MoDOT may renew an exemption upon expiration.

Accordingly, the agency will evaluate the qualifications of each applicant to determine whether issuing a SPE Certificate will comply with the statutory requirements and will achieve the required level of safety. If granted, the SPE Certificate is only applicable to intrastate transportation wholly within Missouri.

Qualifications of Applicants

Application # MP040818062
Applicant's Name & Age: Paul Matthew Kincaid, 37
Relevant Physical Condition: Mr. Kincaid's best corrected visual acuity in his left eye is 20/40 Snellen and he has partial blindness in the direct vision of his right eye due to an accident that occurred in 1987. In his right eye, uncorrected visual acuity is 20/200 Snellen and corrected is 20/80 Snellen.
Relevant Driving Experience: Employed by MoDOT as a dump truck operator from April 2004 to August 2004 and drove 40 hours per week. Has driven a 10 wheeler part-time for Hirsch Feed & Farm

Supply Inc. approximately 25 hours per week from August 1998 to present. Drives personal vehicle(s) daily.
Doctor's Opinion & Date: Following an examination in September 2004, his optometrist certified, "In my medical opinion, Mr. Kincaid's visual deficiency is stable and has sufficient vision to perform the driving tasks required to operate a commercial motor vehicle, and that his condition will not adversely affect his ability to operate a commercial motor vehicle safely."
Traffic Accidents and Violations: No accidents or violations within the past 3 years.

Application # MP040112005
Applicant's Name & Age: Daniel Herbert LaFevers, 33
Relevant Physical Condition: Mr. LaFevers best uncorrected visual acuity in his right eye is 20/20 Snellen and he has a prosthetic left eye due to an injury accident in 1986.
Relevant Driving Experience: Employed by Hiland Dairy Foods, LLC in Springfield, MO as a delivery driver from August 1998 to present and has driven an average of 20 hours per week. Employed as a laborer/mechanic for NAC in Mountain View, MO from 1997 to 1998. Drives personal vehicle(s) daily.
Doctor's Opinion & Date: Following an examination in July 2004, his optometrist certified, "In my medical opinion, Mr. LaFevers' visual deficiency is stable and has sufficient vision to perform the driving tasks required to operate a commercial motor vehicle, and that his condition will not adversely affect his ability to operate a commercial motor vehicle safely."
Traffic Accidents and Violations: Mr. LaFevers was involved in one crash in the last 3 years, not in a commercial motor vehicle. Mr. LaFevers was not cited for a violation as the other driver rear-ended him.

Request for Comments
The Missouri Department of Transportation, Motor Carrier Services Division, pursuant to section 622.555, RSMo, and rule 7 CSR 10-25.010, requests public comment from all interested persons on the applications for issuance of Skill Performance Evaluation Certificates described in this notice. We will consider all comments received before the close of business on the closing date indicated earlier in this notice.

Issued on: January 3, 2005

Jan Skouby, Motor Carrier Services Director, Missouri Department of Transportation.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 10—Air Conservation Commission
Chapter 6—Air Quality Standards, Definitions, Sampling and Reference Methods and Air Pollution Control Regulations for the Entire State of Missouri

IN ADDITION

The Department of Natural Resources filed a proposed amendment to this rule on December 14, 2004 and it was published in the January 18, 2005 *Missouri Register* (30 MoReg 153–163). Subsection (4)(B) is reprinted here to show the corrected language in paragraph (4)(B)2. The words "after May 1998" were inadvertently placed at the end of the paragraph rather than following the text to be deleted in the brackets.

10 CSR 10-6.065 Operating Permits

(4) Basic State Operating Permits.

(B) Notifications. *[All notifications will be submitted in duplicate. The permitting authority will return one (1) copy to the notifier stamped Received. This copy will be kept at the installation to which the notification pertains for inspection purposes.]* **The installation shall file a notification with the permitting authority.** The following schedules apply:

1. Initial notifications. All basic state installations shall file complete operating permit notifications *[within twenty-four (24) months following the administrator's approval of the part 70 operating permit program]* **by May 1998**;

2. Subsequent notifications. Any installation that becomes subject to this section at any time *[following twenty-four (24) months after the administrator's approval of the part 70 operating permit program]* **after May 1998** shall file a complete operating permit notification no later than thirty (30) days after commencement of operations;

3. Renewal notifications. Installations subject to this section shall file complete operating permit notifications for operating permit renewal at least six (6) months before the date the current operating permit expires; *[and]*

4. Notwithstanding the deadlines established in this subsection, a complete operating permit notification filed at any time shall be received for processing*[.]***; and**

5. Starting March 30, 2005, all installations that have an active initial or renewal notification—accepted or with a receipt stamp—shall be deemed to be accepted and subject to the respective expiration date on the notification.

STATE OF MISSOURI
JOINT COMMITTEE ON ADMINISTRATIVE RULES
CINDY KADLEC, DIRECTOR
STATE CAPITOL, ROOM B-8
JEFFERSON CITY, MO 65101
PHONE (573) 751-2443
FAX (573) 751-4778

January 24, 2005

The Honorable Robin Carnahan
Secretary of State
Division of Administrative Rules
Jefferson City, MO 65101

Re:
10 CSR 25-17.010 - Applicability
10 CSR 25-17.020 - Definitions
10 CSR 25-17.030 - Registration and Surcharges
10 CSR 25-17.040 - Reporting and Recordkeeping
10 CSR 25-17.050 - Reporting of Releases and Existing Contamination
10 CSR 25-17.060 - Site Prioritization and Completion
10 CSR 25-17.070 - Closure of Facilities
10 CSR 25-17.080 - Site Characterization and Corrective Action
10 CSR 25-17.090 - Application Procedures
10 CSR 25-17.100 - Participation and Eligibility for Funding
10 CSR 25-17.110 - Eligible Costs
10 CSR 25-17.120 - Payment of Deductible and Limits on Payments
10 CSR 25-17.130 - Suspension of Collection of Surcharges; Reinstatement
10 CSR 25-17.140 - General Reimbursement Procedures
10 CSR 25-17.150 - Claims
10 CSR 25-17.160 - Notification of Abandoned Sites
10 CSR 25-17.170 - Violation of Dry Cleaning Remediation Laws

Dear Secretary Carnahan:

On September 16, 2004 the Joint Committee on Administrative Rules met to consider the above-referenced rules. During that hearing the Joint Committee on Administrative Rules voted to disapprove these rules due to the lack of statutory authority to promulgate the rules in violation of §536.021 RSMo. This letter serves as notice of the Joint Committee on Administrative Rule's disapproval of these rules. Pursuant to §536.021 RSMo. and Executive Order 97-97 these rules shall be held in abeyance and should not be published in the Missouri Register for 30 legislative days.

Sincerely,

Cindy S. Kadlec

Cindy S. Kadlec

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 80—Solid Waste Management

IN ADDITION

Draft Missouri Solid Waste Management Plan—Notice of Availability for Public Review and Comment

The Department of Natural Resources is herein publishing a notice of the availability of the Draft Missouri Solid Waste Management Plan for review and comment by Missouri citizens. In accordance with section 260.225, RSMo, the draft plan has been developed in cooperation with local governments, regional planning commissions, districts and state agencies to encourage, to the maximum extent practical, the use of alternatives to disposal.

The Draft Plan may be viewed at the following locations:

Missouri Participating Libraries (A list of participating libraries may be found in the *Missouri Register* immediately following the contents page.)

The Department of Natural Resources' website at http://www.dnr.mo.gov/alpd/swmp/homeswmp.htm, or by appointment at the following locations:

Missouri Department of Natural Resources
Solid Waste Management Program
1738 East Elm St.
Jefferson City, MO 65101
(Make request for review via fax)
FAX (573) 522-3344

Missouri Department of Natural Resources
Kansas City Regional Office
500 NE Colbern Rd.
Lee's Summit, MO 64086-4710
Phone: (816) 622-7044

Missouri Department of Natural Resources
Northeast Regional Office
1709 Prospect Dr. Suite A
Macon, MO 63552-2602
Phone: (660) 385-2129

Missouri Department of Natural Resources
Kansas City Urban Outreach Office
4750 Troost Avenue
Kansas City, MO 64110
(816) 513-3483

Missouri Department of Natural Resources
St. Louis Urban Outreach Office
4030 Chouteau, 6th Floor
St. Louis, MO 63110
(314) 340-5900

Missouri Department of Natural Resources
St. Louis Regional Office
7545 S. Lindbergh, Suite 210
St. Louis, MO 63125
Phone: (314) 416-2960

Missouri Department of Natural Resources
Southeast Regional Office
2155 North Westwood Boulevard
Poplar Bluff, MO 63901
Phone: (573) 840-9754

Missouri Department of Natural Resources
Southwest Regional Office
2040 W. Woodland
Springfield, MO 65807-5912
Phone: (417) 891-4399

The public is invited to review and comment on the plan during the public comment period, which will end on April 4, 2005. Please send comments to Roger D. Randolph, Director, Solid Waste Management Program, PO Box 176, Jefferson City, MO 65102. Comments should be postmarked no later than April 4, 2005.

For more information, contact Dennis Hansen at (573) 751-5401.

The Secretary of State is required by sections 347.141 and 359.481, RSMo 2000 to publish dissolutions of limited liability companies and limited partnerships. The content requirements for the one-time publishing of these notices are prescribed by statute. This listing is published pursuant to these statutes. We request that documents submitted for publication in this section be submitted in camera ready 8 1/2" x 11" manuscript.

NOTICE OF DISSOLUTION TO ALL CREDITORS AND CLAIMANTS

AGAINST NCPC, INC.

On November 16, 2004, NCPC, Inc., a Missouri corporation, filed its Articles of Dissolution with the Missouri Secretary of State. Dissolution was effective on November 16, 2004.

Said Corporation requests that all persons and organizations who have claims against it present them immediately by letter to the Corporation in care of William B. Prugh, 120 West 12th Street, Suite 1700, Kansas City, Missouri 64105. All claims must include: the name and address of the claimant; the amount claimed; the basis for the claim; and the date(s) on which the event(s) on which the claim is based occurred.

All claims against said Corporation will be barred unless a proceeding to enforce the claim is commenced within two (2) years after the publication date of this notice, or the publication date of any other notice required by law, whichever is later.

NOTICE OF DISSOLUTION OF LIMITED PARTNERSHIP

TO ALL CREDITORS OF AND CLAIMANTS AGAINST THE CROSSROADS OF CAPE GIRARDEAU, L.P.

On December 10, 2004, The Crossroads of Cape Girardeau, L.P., Missouri limited partnership, (hereinafter the "Partnership") filed its Certificate of Cancellation of Limited Partnership with the Missouri Secretary of State, effective on December 13, 2004.

Any claims against the Partnership may be sent to: Fred R. Wilferth, 167 Red Fox Lane, Cape Girardeau, MO 63701. Each claim must include the following information: the name, address and phone number of the claimant; the amount claimed; the date on which the claim arose; the basis for the claim; and documentation for the claim.

All claims against the Partnership will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication of this Notice.

**NOTICE TO THE UNKNOWN CREDITORS
OF
HW EXHIBITS, INC.**

You are hereby notified that on November 3, 2004, HW EXHIBITS, INC., a Missouri profit corporation (the "Company"), the principal office of which is located in St. Louis County, Missouri, filed Articles of Dissolution by Voluntary Action with the Secretary of State of Missouri. Pursuant to Section 351.482 of the General and Business Corporation Law of the State of Missouri, any claims against the Corporation must be mailed to:

HW EXHIBITS, INC.
10601 Baur Blvd.
St. Louis, MO 63132
Attention: Joan Pisoni.

Claims submitted must include the following information: (1) claimant name, address, and phone number; (2) name of debtor; (3) account or other number by which the debtor may identify the creditor; (4) a brief description of the nature of the debt or the basis of the claim; (5) the amount of the claim; (6) the date the claim was incurred; and (7) supporting documentation for the claim, if any.

NOTICE: CLAIMS OF CREDITORS OF THE CORPORATION WILL BE BARRED UNLESS A PROCEEDING TO ENFORCE THE CLAIM IS COMMENCED WITHIN 2 (TWO) YEARS OF THE DATE OF THIS NOTICE.

**NOTICE TO THE UNKNOWN CREDITORS
OF
PRODUCTION PARTNERS INCORPORATED**

You are hereby notified that on November 3, 2004, PRODUCTION PARTNERS INCORPORATED, a Missouri profit corporation (the "Company"), the principal office of which is located in St. Louis County, Missouri, filed Articles of Dissolution by Voluntary Action with the Secretary of State of Missouri. Pursuant to Section 351.482 of the General and Business Corporation Law of the State of Missouri, any claims against the Corporation must be mailed to:

PRODUCTION PARTNERS INCORPORATED
10601 Baur Blvd.
St. Louis, MO 63132
Attention: Joan Pisoni.

Claims submitted must include the following information: (1) claimant name, address, and phone number; (2) name of debtor; (3) account or other number by which the debtor may identify the creditor; (4) a brief description of the nature of the debt or the basis of the claim; (5) the amount of the claim; (6) the date the claim was incurred; and (7) supporting documentation for the claim, if any.

NOTICE: CLAIMS OF CREDITORS OF THE CORPORATION WILL BE BARRED UNLESS A PROCEEDING TO ENFORCE THE CLAIM IS COMMENCED WITHIN 2 (TWO) YEARS OF THE DATE OF THIS NOTICE.

"NOTICE OF WINDING UP FOR LIMITED LIABILITY COMPANY

TO ALL CREDITORS AND CLAIMANTS AGAINST **TOWN & CAMPUS, L.L.C.**, a Missouri limited liability company (the "Company"):

You are hereby notified that the Company has dissolved, effective December 20, 2004, and is in the process of winding up its affairs. All persons having claims against the Company must present their claims in writing and mail their claims to:

Richard A. Pendleton
4200 S. Quail Creek Ave., Suite B
Springfield, MO 65810

A claim against the Company will be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this Notice. In order to file a claim with the Company, you must furnish the following: (a) amount of the claim; (b) basis for the claim; and (c) documentation of the claim."

Notice of Winding Up of Limited Liability Company
To All Creditors of and
Claimants Against
ONSITE IMAGE, LLC

On December 21, 2004, ONSITE IMAGE, LLC, a Missouri limited liability company, filed its Articles of Termination and Notice of Winding Up for Limited Liability Company with the Missouri Secretary of State, effective on December 14, 2004.

Said limited liability company requests that all persons and organizations who have claims against it present them immediately by letter to the company at:

Onsite Image, LLC
Attn: George L. DeMare
1227 Fern Ridge Parkway, Suite 200
St. Louis, MO 63141
(314) 317-9070

With a copy to: Sandberg, Phoenix & von Gontard P.C.
Attn: Bryan P. Cavanaugh, Esq.
One City Centre, 15th Floor
St. Louis, MO 63101
(314) 231-3332

All claims must include the name and address of the claimant; the amount claimed; the basis for the claim; and the date(s) on which the event(s) on which the claim is based occurred.

NOTICE: Because of the notice of winding up of Onsite Image, LLC, any claims against it will be barred unless a proceeding to enforce the claim is commenced within three (3) years after the publication date of the notices authorized by statute, whichever is published last.

**NOTICE TO THE UNKNOWN CREDITORS
OF
BOONE POINT, L.L.C.**

You are hereby notified that on December 6, 2004, Boone Point, L.L.C., a Missouri limited liability company (the "Company"), the principal office of which is located in Taney County, Missouri, filed a Notice of Winding Up with the Secretary of State of Missouri.

In order to file a claim with the Company, you must furnish the amount and the basis for the claim and provide all necessary documentation supporting this claim. All claims must be mailed to:

Boone Point, L.L.C.
In care of Bryan Cave LLP
211 North Broadway, Suite 3600
St. Louis, MO 63102-2750
Attention: John Schaperkotter, Esq.

A claim against Boone Point, L.L.C. will be barred unless a proceeding to enforce the claim is commenced within three years after the publication of this notice.

Rule Changes Since Update to Code of State Regulations

This cumulative table gives you the latest status of rules. It contains citations of rulemakings adopted or proposed after deadline for the monthly Update Service to the *Code of State Regulations*, citations are to volume and page number in the *Missouri Register*, except for material in this issue. The first number in the table cite refers to the volume number or the publication year—27 (2002), 28 (2003), 29 (2004) and 30 (2005). MoReg refers to *Missouri Register* and the numbers refer to a specific *Register* page, R indicates a rescission, W indicates a withdrawal, S indicates a statement of actual cost, T indicates an order terminating a rule, N.A. indicates not applicable, RUC indicates a rule under consideration, and F indicates future effective date.

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	OFFICE OF ADMINISTRATION				
1 CSR 10	State Officials' Salary Compensation Schedule				27 MoReg 189 27 MoReg 1724 28 MoReg 1861 29 MoReg 1610
1 CSR 10-4.010	Commissioner of Administration		28 MoReg 1557	29 MoReg 2320	This Issue
1 CSR 20-1.010	Personnel Advisory Board and Division of Personnel		30 MoReg 148		
1 CSR 20-3.010	Personnel Advisory Board and Division of Personnel		30 MoReg 148		
1 CSR 20-3.020	Personnel Advisory Board and Division of Personnel		30 MoReg 149		
1 CSR 20-3.070	Personnel Advisory Board and Division of Personnel		29 MoReg 1513		
1 CSR 20-5.025	Personnel Advisory Board and Division of Personnel		29 MoReg 1513		
	DEPARTMENT OF AGRICULTURE				
2 CSR 30-2.010	Animal Health	29 MoReg 1417 30 MoReg 139	29 MoReg 1437 30 MoReg 149	30 MoReg 187	
2 CSR 30-2.060	Animal Health			30 MoReg 187	29 MoReg 1480
2 CSR 30-6.020	Animal Health	29 MoReg 1418	29 MoReg 1438		
2 CSR 30-10.010	Animal Health		29 MoReg 2257		
2 CSR 30-22.010	Animal Health		29 MoReg 2257		
2 CSR 70-40.015	Plant Industries		29 MoReg 1439	This Issue	
2 CSR 70-40.025	Plant Industries		29 MoReg 1439	This Issue	
2 CSR 100-7.010	Missouri Agricultural and Small Business Development Authority		30 MoReg 150		
2 CSR 100-10.010	Missouri Agricultural and Small Business Development Authority		30 MoReg 151		
	DEPARTMENT OF CONSERVATION				
3 CSR 10-3.010	Conservation Commission		29 MoReg 1689	30 MoReg 187	
3 CSR 10-4.110	Conservation Commission		29 MoReg 1689	30 MoReg 187	
3 CSR 10-4.111	Conservation Commission		29 MoReg 1690	30 MoReg 188	
3 CSR 10-4.113	Conservation Commission		29 MoReg 1690	30 MoReg 188	
3 CSR 10-5.205	Conservation Commission		29 MoReg 1690	30 MoReg 188	
3 CSR 10-5.215	Conservation Commission		29 MoReg 1691	30 MoReg 188	
3 CSR 10-5.225	Conservation Commission		29 MoReg 1691	30 MoReg 188	
3 CSR 10-5.430	Conservation Commission		29 MoReg 1691	30 MoReg 188	
3 CSR 10-5.565	Conservation Commission		29 MoReg 1692	30 MoReg 188	
3 CSR 10-5.579	Conservation Commission		29 MoReg 1692	30 MoReg 189	
3 CSR 10-6.410	Conservation Commission		29 MoReg 1692	30 MoReg 189	
3 CSR 10-6.415	Conservation Commission		29 MoReg 1692	30 MoReg 189	
3 CSR 10-6.505	Conservation Commission		29 MoReg 1793	This Issue	
3 CSR 10-6.510	Conservation Commission		29 MoReg 1693	30 MoReg 189	
3 CSR 10-6.511	Conservation Commission		N.A.	This Issue	
3 CSR 10-6.525	Conservation Commission		29 MoReg 1693	30 MoReg 189	
3 CSR 10-6.533	Conservation Commission		29 MoReg 1694	30 MoReg 189	
3 CSR 10-6.535	Conservation Commission		29 MoReg 1694	30 MoReg 190	
3 CSR 10-6.605	Conservation Commission		29 MoReg 1695	30 MoReg 190	
3 CSR 10-6.610	Conservation Commission		29 MoReg 1695	30 MoReg 190	
3 CSR 10-6.615	Conservation Commission		29 MoReg 1696	30 MoReg 190	
3 CSR 10-7.410	Conservation Commission		29 MoReg 1696	30 MoReg 190	
3 CSR 10-7.427	Conservation Commission		29 MoReg 1696	30 MoReg 191	
3 CSR 10-7.430	Conservation Commission		29 MoReg 1793	This Issue	
3 CSR 10-7.431	Conservation Commission		29 MoReg 1697	30 MoReg 191	
3 CSR 10-7.438	Conservation Commission		29 MoReg 1794	This Issue	
3 CSR 10-7.455	Conservation Commission		29 MoReg 1697 N.A.	30 MoReg 191 This Issue	 This Issue
3 CSR 10-8.510	Conservation Commission		29 MoReg 1697	30 MoReg 191	
3 CSR 10-8.515	Conservation Commission		29 MoReg 1698	30 MoReg 191	
3 CSR 10-9.105	Conservation Commission		29 MoReg 1698	30 MoReg 191	
3 CSR 10-9.110	Conservation Commission		29 MoReg 1794	This Issue	
3 CSR 10-9.220	Conservation Commission		29 MoReg 1699	30 MoReg 192	
3 CSR 10-9.240	Conservation Commission		29 MoReg 1699	30 MoReg 192	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
3 CSR 10-9.353	Conservation Commission		29 MoReg 1440	29 MoReg 2321	
3 CSR 10-9.425	Conservation Commission		29 MoReg 1699	30 MoReg 192	
3 CSR 10-9.440	Conservation Commission		29 MoReg 1700	30 MoReg 192	
3 CSR 10-9.565	Conservation Commission		29 MoReg 1440	29 MoReg 2321	
3 CSR 10-9.566	Conservation Commission		29 MoReg 1700	30 MoReg 192	
3 CSR 10-9.570	Conservation Commission		29 MoReg 1700	30 MoReg 192	
3 CSR 10-9.575	Conservation Commission		29 MoReg 1701	30 MoReg 193	
3 CSR 10-9.625	Conservation Commission		29 MoReg 1701	30 MoReg 193	
3 CSR 10-10.705	Conservation Commission		29 MoReg 1701	30 MoReg 193	
3 CSR 10-10.725	Conservation Commission		29 MoReg 1702	30 MoReg 193	
3 CSR 10-10.732	Conservation Commission		29 MoReg 1702	30 MoReg 193	
3 CSR 10-11.120	Conservation Commission		29 MoReg 1703	30 MoReg 194	
3 CSR 10-11.125	Conservation Commission		29 MoReg 1703	30 MoReg 194	
3 CSR 10-11.145	Conservation Commission		29 MoReg 1703	30 MoReg 194	
3 CSR 10-11.150	Conservation Commission		29 MoReg 1704	30 MoReg 194	
3 CSR 10-11.155	Conservation Commission		29 MoReg 1704	30 MoReg 194	
3 CSR 10-11.180	Conservation Commission		29 MoReg 1795	This Issue	
3 CSR 10-11.182	Conservation Commission		29 MoReg 1797	This Issue	
3 CSR 10-11.183	Conservation Commission		29 MoReg 1799R	This IssueR	
3 CSR 10-11.186	Conservation Commission		29 MoReg 1704	30 MoReg 194	
3 CSR 10-11.187	Conservation Commission		29 MoReg 1705	30 MoReg 195	
3 CSR 10-11.205	Conservation Commission		29 MoReg 1705	30 MoReg 195	
3 CSR 10-11.210	Conservation Commission		29 MoReg 1706	30 MoReg 195	
3 CSR 10-11.215	Conservation Commission		29 MoReg 1707	30 MoReg 195	
3 CSR 10-12.109	Conservation Commission		29 MoReg 1707	30 MoReg 195	
3 CSR 10-12.110	Conservation Commission		29 MoReg 1799	This Issue	
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3 CSR 10-12.150	Conservation Commission		29 MoReg 1708	30 MoReg 196	
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4 CSR 95-2.040	Committee for Professional Counselors		30 MoReg 29R		
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4 CSR 230-2.050	State Board of Podiatric Medicine		29 MoReg 1451		
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4 CSR 240-29.010	Public Service Commission		30 MoReg 49		
4 CSR 240-29.020	Public Service Commission		30 MoReg 50		
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15 CSR 40-3.140	State Auditor	29 MoReg 1651	29 MoReg 2274		
15 CSR 40-3.150	State Auditor	29 MoReg 1661	29 MoReg 2284		
15 CSR 40-3.160	State Auditor	29 MoReg 1673	29 MoReg 2296		
15 CSR 60-14.010	Attorney General	29 MoReg 1508	29 MoReg 1557		
15 CSR 60-14.020	Attorney General	29 MoReg 1509	29 MoReg 1557		
15 CSR 60-14.030	Attorney General	29 MoReg 1509	29 MoReg 1557		
	RETIREMENT SYSTEMS				
16 CSR 20-2.057	Missouri Local Government Employees' Retirement System (LAGERS)		30 MoReg 93		
16 CSR 50-10.050	The County Employees' Retirement Fund		29 MoReg 1469	This Issue	
16 CSR 50-10.070	The County Employees' Retirement Fund		29 MoReg 1247	29 MoReg 2330	

Rule Number	Agency	Emergency	Proposed	Order	In Addition
	DEPARTMENT OF HEALTH AND SENIOR SERVICES				
19 CSR 20-3.080	Division of Environmental Health and Communicable Disease Prevention	29 MoReg 1510	29 MoReg 1560R 29 MoReg 1560	30 MoReg 196R 30 MoReg 197	
19 CSR 20-20.010	Division of Environmental Health and Communicable Disease Prevention		29 MoReg 1733		
19 CSR 20-20.020	Division of Environmental Health and Communicable Disease Prevention		29 MoReg 1734		
19 CSR 20-50.005	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 140	30 MoReg 173		
19 CSR 20-50.010	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 141	30 MoReg 174		
19 CSR 20-50.015	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 141	30 MoReg 174		
19 CSR 20-50.020	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 142	30 MoReg 176		
19 CSR 20-50.025	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 143	30 MoReg 178		
19 CSR 20-50.030	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 144	30 MoReg 180		
19 CSR 20-50.035	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 145	30 MoReg 183		
19 CSR 20-50.040	Division of Environmental Health and Communicable Disease Prevention	30 MoReg 145	30 MoReg 185		
19 CSR 30-60.010	Division of Senior Services and Regulation		29 MoReg 1817R 29 MoReg 1818		
19 CSR 30-60.015	Division of Senior Services and Regulation		29 MoReg 1819		
19 CSR 30-60.020	Division of Health Standards and Licensure		29 MoReg 1819R		
19 CSR 30-60.025	Division of Senior Services and Regulation		29 MoReg 1820		
19 CSR 30-60.030	Division of Health Standards and Licensure		29 MoReg 1824R		
19 CSR 30-60.035	Division of Senior Services and Regulation		29 MoReg 1824		
19 CSR 30-60.040	Division of Health Standards and Licensure		29 MoReg 1828R		
19 CSR 30-60.045	Division of Senior Services and Regulation		29 MoReg 1828		
19 CSR 30-60.050	Division of Health Standards and Licensure		29 MoReg 1832R		
19 CSR 30-60.055	Division of Senior Services and Regulation		29 MoReg 1832		
19 CSR 30-60.060	Division of Health Standards and Licensure		29 MoReg 1836R		
19 CSR 30-60.061	Division of Senior Services and Regulation		29 MoReg 1836		
19 CSR 30-60.065	Division of Senior Services and Regulation		29 MoReg 1843		
19 CSR 30-60.070	Division of Health Standards and Licensure		29 MoReg 1848R		
19 CSR 30-60.071	Division of Senior Services and Regulation		29 MoReg 1848		
19 CSR 30-60.075	Division of Senior Services and Regulation		29 MoReg 1852		
19 CSR 30-60.080	Division of Senior Services and Regulation		29 MoReg 1855R 29 MoReg 1855		
19 CSR 30-60.090	Division of Senior Services and Regulation		29 MoReg 1864R 29 MoReg 1864		
19 CSR 30-60.095	Division of Senior Services and Regulation		29 MoReg 1874		
19 CSR 30-60.100	Division of Health Standards and Licensure		29 MoReg 1878R		
19 CSR 30-60.105	Division of Senior Services and Regulation		29 MoReg 1878		
19 CSR 30-60.110	Division of Health Standards and Licensure		29 MoReg 1882R		
19 CSR 30-60.115	Division of Senior Services and Regulation		29 MoReg 1882		
19 CSR 30-60.120	Division of Health Standards and Licensure		29 MoReg 1887R		
19 CSR 30-60.125	Division of Senior Services and Regulation		29 MoReg 1887		
19 CSR 30-60.135	Division of Senior Services and Regulation		29 MoReg 1891		
19 CSR 30-60.145	Division of Senior Services and Regulation		29 MoReg 1895		
19 CSR 30-60.155	Division of Senior Services and Regulation		29 MoReg 1898		
19 CSR 30-61.010	Division of Senior Services and Regulation		29 MoReg 1901R 29 MoReg 1901		
19 CSR 30-61.015	Division of Senior Services and Regulation		29 MoReg 1903R 29 MoReg 1903		
19 CSR 30-61.025	Division of Health Standards and Licensure		29 MoReg 1906R		
19 CSR 30-61.045	Division of Senior Services and Regulation		29 MoReg 1906R 29 MoReg 1906		
19 CSR 30-61.055	Division of Senior Services and Regulation		29 MoReg 1911R 29 MoReg 1911		
19 CSR 30-61.060	Division of Senior Services and Regulation		29 MoReg 1915		
19 CSR 30-61.065	Division of Senior Services and Regulation		29 MoReg 1919		
19 CSR 30-61.070	Division of Senior Services and Regulation		29 MoReg 1926		
19 CSR 30-61.075	Division of Senior Services and Regulation		29 MoReg 1932		
19 CSR 30-61.080	Division of Senior Services and Regulation		29 MoReg 1937		
19 CSR 30-61.085	Division of Health Standards and Licensure		29 MoReg 1940R		
19 CSR 30-61.086	Division of Senior Services and Regulation		29 MoReg 1940R 29 MoReg 1940		
19 CSR 30-61.090	Division of Senior Services and Regulation		29 MoReg 1948		
19 CSR 30-61.095	Division of Health Standards and Licensure		29 MoReg 1957R		

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19 CSR 30-61.100	Division of Senior Services and Regulation		29 MoReg 1957		
19 CSR 30-61.105	Division of Health Standards and Licensure		29 MoReg 1964R		
19 CSR 30-61.110	Division of Senior Services and Regulation		29 MoReg 1964		
19 CSR 30-61.115	Division of Health Standards and Licensure		29 MoReg 1969R		
19 CSR 30-61.120	Division of Senior Services and Regulation		29 MoReg 1969		
19 CSR 30-61.125	Division of Health Standards and Licensure		29 MoReg 1975R		
19 CSR 30-61.130	Division of Senior Services and Regulation		29 MoReg 1975		
19 CSR 30-61.135	Division of Health Standards and Licensure		29 MoReg 1981R		
19 CSR 30-61.140	Division of Senior Services and Regulation		29 MoReg 1981		
19 CSR 30-61.145	Division of Health Standards and Licensure		29 MoReg 1986R		
19 CSR 30-61.150	Division of Senior Services and Regulation		29 MoReg 1986		
19 CSR 30-61.151	Division of Senior Services and Regulation		29 MoReg 1997		
19 CSR 30-61.155	Division of Senior Services and Regulation		29 MoReg 2001R 29 MoReg 2001		
19 CSR 30-61.165	Division of Senior Services and Regulation		29 MoReg 2005R 29 MoReg 2005		
19 CSR 30-61.170	Division of Senior Services and Regulation		29 MoReg 2009		
19 CSR 30-61.175	Division of Health Standards and Licensure		29 MoReg 2013R		
19 CSR 30-61.180	Division of Senior Services and Regulation		29 MoReg 2013		
19 CSR 30-61.185	Division of Health Standards and Licensure		29 MoReg 2017R		
19 CSR 30-61.190	Division of Health Standards and Licensure		29 MoReg 2017R		
19 CSR 30-61.200	Division of Health Standards and Licensure		29 MoReg 2017R		
19 CSR 30-61.210	Division of Health Standards and Licensure		29 MoReg 2017R		
19 CSR 30-61.220	Division of Senior Services and Regulation		29 MoReg 2018R 29 MoReg 2018		
19 CSR 30-61.230	Division of Senior Services and Regulation		29 MoReg 2022		
19 CSR 30-62.010	Division of Senior Services and Regulation		29 MoReg 2024R 29 MoReg 2024		
19 CSR 30-62.022	Division of Senior Services and Regulation		29 MoReg 2026R 29 MoReg 2026		
19 CSR 30-62.032	Division of Health Standards and Licensure		29 MoReg 2029R		
19 CSR 30-62.042	Division of Senior Services and Regulation		29 MoReg 2029R 29 MoReg 2029		
19 CSR 30-62.052	Division of Senior Services and Regulation		29 MoReg 2034R 29 MoReg 2034		
19 CSR 30-62.060	Division of Senior Services and Regulation		29 MoReg 2038		
19 CSR 30-62.065	Division of Senior Services and Regulation		29 MoReg 2042		
19 CSR 30-62.070	Division of Senior Services and Regulation		29 MoReg 2049		
19 CSR 30-62.075	Division of Senior Services and Regulation		29 MoReg 2055		
19 CSR 30-62.080	Division of Senior Services and Regulation		29 MoReg 2060		
19 CSR 30-62.082	Division of Health Standards and Licensure		29 MoReg 2063R		
19 CSR 30-62.087	Division of Senior Services and Regulation		29 MoReg 2063R 29 MoReg 2063		
19 CSR 30-62.090	Division of Senior Services and Regulation		29 MoReg 2072		
19 CSR 30-62.092	Division of Health Standards and Licensure		29 MoReg 2082R		
19 CSR 30-62.100	Division of Senior Services and Regulation		29 MoReg 2082		
19 CSR 30-62.102	Division of Health Standards and Licensure		29 MoReg 2090R		
19 CSR 30-62.112	Division of Senior Services and Regulation		29 MoReg 2090R 29 MoReg 2090		
19 CSR 30-62.120	Division of Senior Services and Regulation		29 MoReg 2095		
19 CSR 30-62.122	Division of Health Standards and Licensure		29 MoReg 2100R		
19 CSR 30-62.125	Division of Senior Services and Regulation		29 MoReg 2100		
19 CSR 30-62.130	Division of Senior Services and Regulation		29 MoReg 2105		
19 CSR 30-62.132	Division of Health Standards and Licensure		29 MoReg 2111R		
19 CSR 30-62.140	Division of Senior Services and Regulation		29 MoReg 2111		
19 CSR 30-62.142	Division of Health Standards and Licensure		29 MoReg 2116R		
19 CSR 30-62.150	Division of Senior Services and Regulation		29 MoReg 2116		
19 CSR 30-62.151	Division of Senior Services and Regulation		29 MoReg 2121		
19 CSR 30-62.152	Division of Health Standards and Licensure		29 MoReg 2126R		
19 CSR 30-62.162	Division of Senior Services and Regulation		29 MoReg 2126R 29 MoReg 2126		
19 CSR 30-62.172	Division of Senior Services and Regulation		29 MoReg 2130R 29 MoReg 2130		
19 CSR 30-62.182	Division of Health Standards and Licensure		29 MoReg 2134R		
19 CSR 30-62.192	Division of Health Standards and Licensure		29 MoReg 2134R		
19 CSR 30-62.202	Division of Health Standards and Licensure		29 MoReg 2134R		
19 CSR 30-62.212	Division of Health Standards and Licensure		29 MoReg 2134R		
19 CSR 30-62.222	Division of Senior Services and Regulation		29 MoReg 2135R 29 MoReg 2135		
19 CSR 30-62.224	Division of Senior Services and Regulation		29 MoReg 2140		
19 CSR 30-62.226	Division of Senior Services and Regulation		29 MoReg 2146		
19 CSR 30-62.228	Division of Senior Services and Regulation		29 MoReg 2149		
19 CSR 30-62.230	Division of Senior Services and Regulation		29 MoReg 2152R 29 MoReg 2152		

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19 CSR 30-62.240	Division of Senior Services and Regulation		29 MoReg 2156		
19 CSR 30-82.050	Division of Senior Services and Regulation		29 MoReg 2305		
19 CSR 30-82.090	Division of Health Standards and Licensure		28 MoReg 2254		
19 CSR 30-83.010	Division of Senior Services and Regulation		29 MoReg 1567	This Issue	
19 CSR 30-86.012	Division of Health Standards and Licensure		29 MoReg 2307		
19 CSR 30-86.022	Division of Health Standards and Licensure		29 MoReg 1362	30 MoReg 106	
19 CSR 30-86.032	Division of Health Standards and Licensure		29 MoReg 2308		
19 CSR 30-86.042	Division of Health Standards and Licensure		29 MoReg 2309		
19 CSR 30-89.010	Division of Health Standards and Licensure		29 MoReg 1568R	This IssueR	
19 CSR 30-90.010	Division of Senior Services and Regulation		29 MoReg 1569	This Issue	
19 CSR 30-90.020	Division of Senior Services and Regulation		29 MoReg 1570	This Issue	
19 CSR 30-90.030	Division of Health Standards and Licensure		29 MoReg 1574R	This IssueR	
19 CSR 30-90.040	Division of Senior Services and Regulation		29 MoReg 1574	This Issue	
19 CSR 30-90.050	Division of Senior Services and Regulation		29 MoReg 1579	This Issue	
19 CSR 30-90.060	Division of Senior Services and Regulation		29 MoReg 1581	This Issue	
19 CSR 30-90.070	Division of Senior Services and Regulation		29 MoReg 1582	This Issue	
19 CSR 30-90.080	Division of Health Standards and Licensure		29 MoReg 1587R	This IssueR	
19 CSR 60-50	Missouri Health Facilities Review Committee				29 MoReg 1480 29 MoReg 1608 29 MoReg 2332 30 MoReg 201
	DEPARTMENT OF INSURANCE				
20 CSR	Medical Malpractice				27 MoReg 415 28 MoReg 489 29 MoReg 505
20 CSR	Sovereign Immunity Limits				27 MoReg 41 27 MoReg 2319 28 MoReg 2265 30 MoReg 108
20 CSR 10-1.020	General Administration		29 MoReg 1368	30 MoReg 106	
20 CSR 400-2.170	Life, Annuities and Health		29 MoReg 1755		
20 CSR 500-2.300	Property and Casualty		29 MoReg 2223		
20 CSR 700-6.100	Licensing	29 MoReg 2209	29 MoReg 1587		
20 CSR 700-6.150	Licensing	29 MoReg 2209	29 MoReg 1590		
20 CSR 700-6.160	Licensing		29 MoReg 1593		
20 CSR 700-6.170	Licensing		29 MoReg 1597		
20 CSR 700-6.200	Licensing		29 MoReg 1597		
20 CSR 700-6.250	Licensing		29 MoReg 1598		
20 CSR 700-6.300	Licensing		29 MoReg 1598		
	MISSOURI CONSOLIDATED HEALTH CARE PLAN				
22 CSR 10-2.010	Health Care Plan	This IssueR	This IssueR		
22 CSR 10-2.020	Health Care Plan	This IssueR This Issue	This IssueR This Issue		
22 CSR 10-2.030	Health Care Plan	This IssueR This Issue	This IssueR This Issue		
22 CSR 10-2.045	Health Care Plan	This IssueR This Issue	This IssueR This Issue		
22 CSR 10-2.055	Health Care Plan	This IssueR This Issue	This IssueR This Issue		
22 CSR 10-2.070	Health Care Plan	This IssueR This Issue	This IssueR This Issue		
22 CSR 10-2.075	Health Care Plan	This IssueR This Issue	This IssueR This Issue		
22 CSR 10-2.080	Health Care Plan	This IssueR This Issue	This IssueR This Issue		
22 CSR 10-3.010	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.020	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.030	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.070	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.075	Health Care Plan	This Issue	This Issue		
22 CSR 10-3.080	Health Care Plan	This Issue	This Issue		

Emergency Rules in Effect as of February 1, 2005

		Publication	Expires
Department of Agriculture			
Animal Health			
2 CSR 30-2.010	Health Requirements Governing the Admission of Livestock, Poultry and Exotic Animals Entering Missouri	29 MoReg 1417	March 1, 2005
2 CSR 30-2.010	Health Requirements Governing the Admission of Livestock, Poultry and Exotic Animals Entering Missouri	30 MoReg 139	May 31, 2005
2 CSR 30-6.020	Duties and Facilities of the Market/Sale Veterinarian	29 MoReg 1418	March 1, 2005
Department of Economic Development			
Athlete Agents			
4 CSR 45-1.010	Fees	29 MoReg 1420	March 7, 2005
Department of Mental Health			
Director, Department of Mental Health			
9 CSR 10-31.014	Waiver of Standard Means Test for Children in Need of Mental Health Services	29 MoReg 1507	March 13, 2005
Certification Standards			
9 CSR 30-3.132	Opioid Treatment Program	29 MoReg 2255	May 16, 2005
Division of Mental Retardation and Developmental Disabilities			
9 CSR 45-2.015	Criteria for MRDD Comprehensive Waiver Slot Assignment	29 MoReg 1635	April 15, 2005
Department of Public Safety			
Division of Fire Safety			
11 CSR 40-3.010	Fireworks—Licenses, Sales and Penalties	29 MoReg 1420	March 7, 2005
11 CSR 40-3.010	Fireworks—Licensing, Permits, Sales, Inspection, and Penalties	29 MoReg 1420	March 7, 2005
Missouri State Highway Patrol			
11 CSR 50-2.311	Bumpers	29 MoReg 1426	March 9, 2005
11 CSR 50-2.320	School Bus Inspection	29 MoReg 1428	March 9, 2005
Department of Revenue			
Director of Revenue			
12 CSR 10-41.010	Annual Adjusted Rate of Interest	30 MoReg 5	June 29, 2005
12 CSR 10-400.200	Special Needs Adoption Tax Credit	Next Issue	July 15, 2005
Department of Social Services			
Children's Division			
13 CSR 35-30.010	Voluntary Placement Agreement Solely for the Purpose of Accessing Mental Health Services and Treatment for Children Under Age Eighteen (18)	This Issue	June 30, 2005
13 CSR 35-50.010	Accreditation as Evidence for Meeting Licensing Requirements	This Issue	June 30, 2005
13 CSR 35-80.010	Residential Foster Care Maintenance Methodology	29 MoReg 1636	March 30, 2005
13 CSR 35-80.020	Residential Care Agency Cost Reporting System	29 MoReg 1637	March 30, 2005
Family Support Division			
13 CSR 40-19.020	Low Income Home Energy Assistance Program	29 MoReg 1637	April 1, 2005
Division of Medical Services			
13 CSR 70-10.110	Nursing Facility Reimbursement Allowance	This Issue	June 29, 2005
13 CSR 70-15.110	Federal Reimbursement Allowance (FRA)	29 MoReg 1508	March 18, 2005
Elected Officials			
Secretary of State			
15 CSR 30-54.215	Accredited Investor Exemption	29 MoReg 1428	March 9, 2005
15 CSR 30-54.215	Accredited Investor Exemption	29 MoReg 1428	March 9, 2005
State Auditor			
15 CSR 40-3.120	Calculation and Revision of Property Tax Rates	29 MoReg 1639	April 1, 2005
15 CSR 40-3.130	Calculation and Revision of Property Tax Rates by School Districts Calculating a Separate Tax Rate for Each Sub-Class of Property	29 MoReg 1639	April 1, 2005
15 CSR 40-3.140	Calculation and Revision of Property Tax Rates by School Districts that Calculate a Single Property Tax Rate Applied to All Property	29 MoReg 1651	April 1, 2005

15 CSR 40-3.150	Calculation and Revision of Property Tax Rates by Political Subdivisions Other Than School Districts Calculating a Separate Property Tax Rate for Each Sub-Class of Property	29 MoReg 1661	April 1, 2005
15 CSR 40-3.160	Calculation and Revision of Property Tax Rates by Political Subdivision Other Than School Districts that Calculate a Single Property Tax Rate Applied to All Property	29 MoReg 1673	April 1, 2005
Attorney General			
15 CSR 60-14.010	Definitions	29 MoReg 1508	March 10, 2005
15 CSR 60-14.020	Contract Procedures	29 MoReg 1509	March 10, 2005
15 CSR 60-14.030	Documentation of Legal Practice	29 MoReg 1509	March 10, 2005

Department of Health and Senior Services

Division of Environmental Health and Communicable Disease Prevention

19 CSR 20-3.080	Description of Persons Qualified to Perform Percolation Tests, Soils Morphology Examinations in Determining Soil Properties for On-Site Sewage Disposal Systems and Installation of On-Site Wastewater Treatment Systems	29 MoReg 1510	March 10, 2005
19 CSR 20-50.005	Definitions	30 MoReg 140	June 29, 2005
19 CSR 20-50.010	Eligibility Requirements for Pharmacies, Hospitals and Nonprofit Clinics to Receive Donated Prescription Drugs	30 MoReg 141	June 29, 2005
19 CSR 20-50.015	Eligibility Requirements for Recipients in the Program	30 MoReg 141	June 29, 2005
19 CSR 20-50.020	Standards and Procedures for Donating Prescription Drugs	30 MoReg 142	June 29, 2005
19 CSR 20-50.025	Standards and Procedures for Accepting Donated Prescription Drugs	30 MoReg 143	June 29, 2005
19 CSR 20-50.030	Standards and Procedures for Inspecting and Storing Donated Prescription Drugs	30 MoReg 144	June 29, 2005
19 CSR 20-50.035	Standards and Procedures for Dispensing Donated Prescription Drugs	30 MoReg 145	June 29, 2005
19 CSR 20-50.040	Record Keeping Requirements	30 MoReg 145	June 29, 2005

Department of Insurance

Licensing

20 CSR 700-6.100	Fees and Renewals—Bail Bond Agents, General Bail Bond Agents and Surety Recovery Agents	29 MoReg 2209	June 29, 2005
20 CSR 700-6.150	Initial Basic Training for Bail Bond Agents, General Bail Bond Agents and Surety Recovery Agents	29 MoReg 2209	June 29, 2005

Missouri Consolidated Health Care Plan

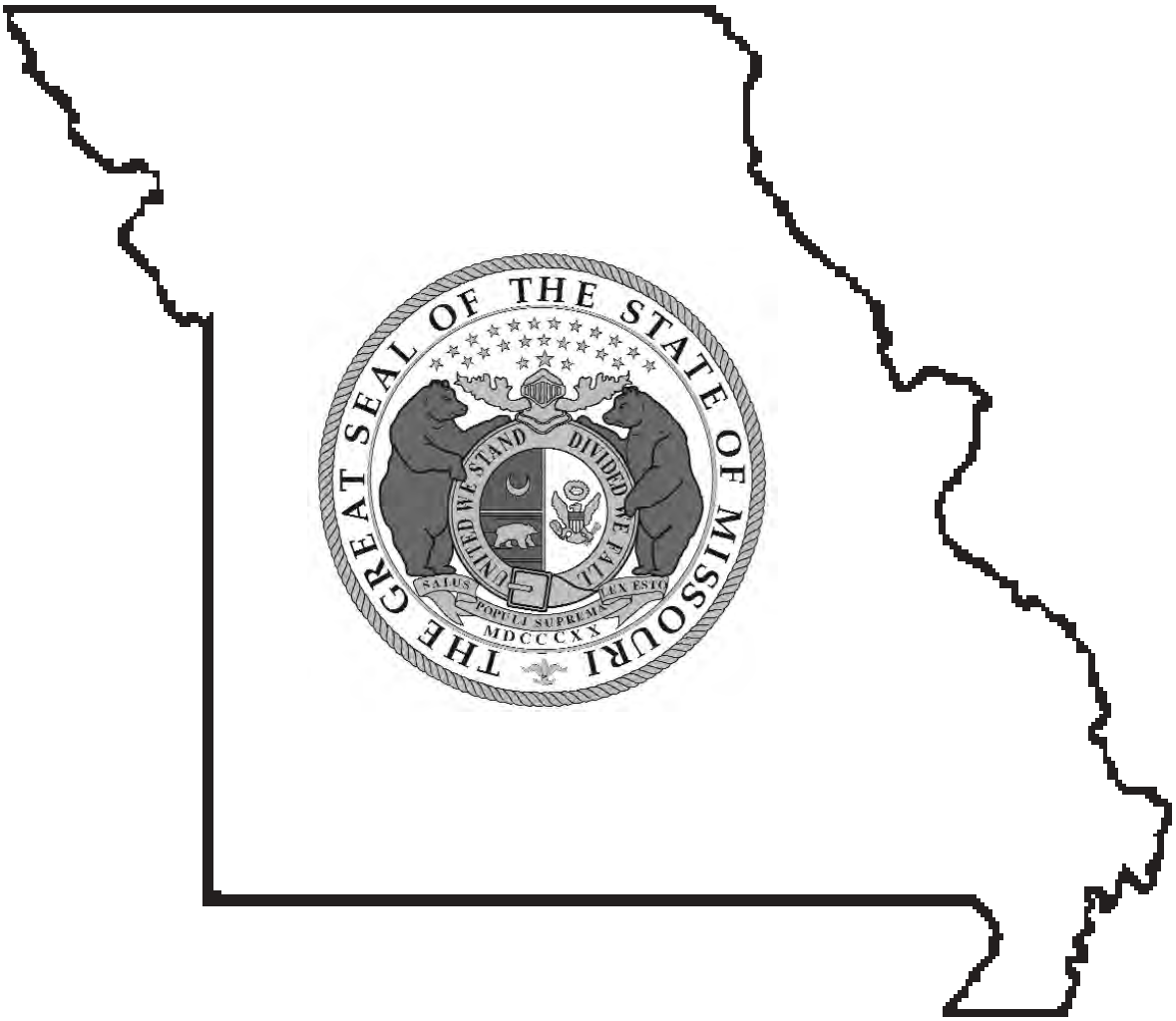
Health Care Plan

22 CSR 10-2.010	Definitions	This Issue	June 29, 2005
22 CSR 10-2.010	Definitions	This Issue	June 29, 2005
22 CSR 10-2.020	Membership Agreement and Participation Agreement	This Issue	June 29, 2005
22 CSR 10-2.020	Subscriber Agreement and General Membership Provisions	This Issue	June 29, 2005
22 CSR 10-2.030	Contributions	This Issue	June 29, 2005
22 CSR 10-2.030	Contributions	This Issue	June 29, 2005
22 CSR 10-2.045	Co-Pay and PPO Plan Summaries	This Issue	June 29, 2005
22 CSR 10-2.045	Plan Utilization Review Policy	This Issue	June 29, 2005
22 CSR 10-2.055	Co-Pay and PPO Plan Benefit Provisions and Covered Charges	This Issue	June 29, 2005
22 CSR 10-2.055	Medical Plan Benefit Provisions and Covered Charges	This Issue	June 29, 2005
22 CSR 10-2.070	Coordination of Benefits	This Issue	June 29, 2005
22 CSR 10-2.070	Coordination of Benefits	This Issue	June 29, 2005
22 CSR 10-2.075	Review and Appeals Procedure	This Issue	June 29, 2005
22 CSR 10-2.075	Review and Appeals Procedure	This Issue	June 29, 2005
22 CSR 10-2.080	Miscellaneous Provisions	This Issue	June 29, 2005
22 CSR 10-2.080	Miscellaneous Provisions	This Issue	June 29, 2005
22 CSR 10-3.010	Definitions	This Issue	June 29, 2005
22 CSR 10-3.020	Subscriber Agreement and General Membership Provisions	This Issue	June 29, 2005
22 CSR 10-3.030	Public Entity Membership Agreement and Participation Period	This Issue	June 29, 2005
22 CSR 10-3.070	Coordination of Benefits	This Issue	June 29, 2005
22 CSR 10-3.075	Review and Appeals Procedure	This Issue	June 29, 2005
22 CSR 10-3.080	Miscellaneous Provisions	This Issue	June 29, 2005

Executive Orders	Subject Matter	Filed Date	Publication
	2005		
05-01	Rescinds Executive Order 01-09	January 11, 2005	This Issue
05-02	Restricts new lease and purchase of vehicles, cellular phones, and office space by executive agencies	January 11, 2005	This Issue
05-03	Closes state's Washington D.C. office	January 11, 2005	This Issue
05-04	Authorizes Transportation Director to issue declaration of regional or local emergency with reference to motor carriers	January 11, 2005	This Issue
05-05	Establishes the 2005 Missouri State Government Review Commission	January 24, 2005	Next Issue
	2004		
04-01	Establishes the Public Safety Officer Medal of Valor, and the Medal of Valor Review Board	February 3, 2004	29 MoReg 294
04-02	Designates staff having supervisory authority over agencies	February 3, 2004	29 MoReg 297
04-03	Creates the Missouri Automotive Partnership	January 14, 2004	29 MoReg 151
04-04	Creates the Missouri Methamphetamine Education and Prevention Task Force	January 27, 2004	29 MoReg 154
04-05	Establishes a Missouri Methamphetamine Treatment Task Force	January 27, 2004	29 MoReg 156
04-06	Establishes a Missouri Methamphetamine Enforcement and Environmental Protection Task Force	January 27, 2004	29 MoReg 158
04-07	Establishes the Missouri Commission on Patient Safety and supercedes Executive Order 03-16	February 3, 2004	29 MoReg 299
04-08	Transfers the Governor's Council on Disability and the Missouri Assistive Technology Advisory Council to the Office of Administration	February 3, 2004	29 MoReg 301
04-09	Requires vendors to disclose services performed offshore. Restricts agencies in awarding contracts to vendors of offshore services	March 17, 2004	29 MoReg 533
04-10	Grants authority to Director of Department of Natural Resources to temporarily waive regulations during periods of emergency and recovery	May 28, 2004	29 MoReg 965
04-11	Declares regional state of emergency because of the need to repair electrical outages by various contractors, including a Missouri contractor. Allows temporary exemption from federal regulations	May 28, 2004	29 MoReg 967
04-12	Declares emergency conditions due to severe weather in all Northern and Central Missouri counties	June 4, 2004	29 MoReg 968
04-13	Declares June 11, 2004 to be day of mourning for President Ronald Reagan	June 7, 2004	29 MoReg 969
04-14	Establishes an Emancipation Day Commission. Requests regular observance of Emancipation Proclamation on June 19	June 17, 2004	29 MoReg 1045
04-15	Declares state of emergency due to lost electrical service in St. Louis region	July 7, 2004	29 MoReg 1159
04-16	Orders a special census be taken in the City of Licking	July 23, 2004	29 MoReg 1245
04-17	Declares that Missouri implement the Emergency Mutual Aid Compact (EMAC) agreement with the State of Florida	August 18, 2004	29 MoReg 1347
04-18	Accepts retrocession of federal jurisdiction over the St. Louis Army Ammunition Plant	August 25, 2004	29 MoReg 1349
04-19	Implements the EMAC with the State of Florida, activates the EMAC plan, and authorizes the use of the Missouri National Guard	September 10, 2004	29 MoReg 1430
04-20	Reestablishes the Poultry Industry Committee	September 14, 2004	29 MoReg 1432
04-21	Directs the creation of the Forest Utilization Committee within the Missouri Department of Conservation	September 14, 2004	29 MoReg 1434
04-22	Requests health care providers limit influenza vaccinations to high risk persons. Orders various actions by providers, Missouri Department of Health and Senior Services, and Attorney General's Office regarding influenza vaccine supply.	October 25, 2004	29 MoReg 1683
04-23	Creates the Forest Utilization Committee within the Missouri Department of Conservation. Supersedes and rescinds Executive Order 04-21	October 22, 2004	29 MoReg 1685
04-24	Rescinds Executive Order 03-15	October 22, 2004	29 MoReg 1687
04-25	Rescinds Executive Order 03-27	October 22, 2004	29 MoReg 1688
04-26	Authorizes Adjutant General to recognize Noncommissioned Officers with a First Sergeant's ribbon	November 1, 2004	29 MoReg 1791
04-27	Closes state offices Friday November 26, 2004	November 1, 2004	29 MoReg 1792
04-28	Closes state offices Monday, January 10, 2005	December 6, 2004	29 MoReg 2256
04-29	Rescinds Executive Order 04-22	January 4, 2005	30 MoReg 147

The rule number and the MoReg publication date follow each entry to this index.

RULEMAKING 1-2-3
MISSOURI STYLE



ROBIN CARNAHAN
SECRETARY OF STATE

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